Leonard Cheshire Disability

The Grange - Care Home Physical Disabilities

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection was unannounced on 21, 22 and 23 September 2016.

The Grange is a care home for up to 27 adults who have a physical disability. There are four apartments on the ground floor of the home providing accommodation for a total of 20 people and a further living unit on the first floor providing further accommodation for people either on a temporary or permanent basis. Nursing care is not provided.

There is a registered manager at the home who has been registered since 2011. 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.

We inspected The Grange in December 2013 and did not identify any concerns. At this inspection we identified three breaches in the regulations and other areas for improvement.

Most people living at The Grange were able to tell us their experiences. There were a small number of people who had complex needs and or were living with dementia and were not able to tell us their experiences. We saw that those people and the people we spoke with were happy and relaxed in the home.

The medicines management at the home was not consistently safe. There were gaps in the administration of medicines, some people did not receive their medicines as prescribed and there were not any PRN 'as needed' medicine plans in place for people who needed them.

Risks to some people's safety were not consistently assessed and managed to minimise risks. Staff did not always follow care plans that were in place for some people. This potentially placed these people at risk. These shortfalls in medicines and risk management were breaches of the regulations.

There was a high turnover of staff, high agency staff usage and people and some staff told us there were not always enough staff to meet people's needs at certain times of the day. There was a recruitment plan in place. These staffing shortfalls were a breach of the regulations.

Some people did not always receive the care and treatment they needed and this placed them at risk. Those people at risk were people living with dementia, those who experienced pain, those who were nutritionally at risk, those who needed their fluids monitoring and those with complex physical care needs. These shortfalls were a breach of the regulations. The manager took immediate action in response to the concerns we raised.

The governance and quality monitoring systems were not fully effective because they did not identify the

shortfalls found at the inspection.

People received the health care they needed and health and social care professionals commented on the good working relationships with the staff.

People told us they felt safe at the home. Staff knew how to recognise any signs of abuse and the manager was working with the local authority safeguarding teams to improve how they responded to safeguarding concerns.

Staff had an understanding of the Mental Capacity Act (2005) and how it applied to their work. Records showed appropriate mental capacity assessments had been carried out and applications for a Deprivation of Liberty Safeguard (DoLs) had been made where these were required.

People's care plans were personalised and focused on them as individuals. People told us they had been involved in developing their care plans. Those people who were not able to make their needs or views known would benefit from having their care plans and records reviewed on a more frequent basis.

Staff were caring and treated people with dignity and respect. People and staff had good relationships. People had access to the local community and had pursued individual activities. Some people had identified that social occupation was an area for improvement.

Staff received an induction, core training and some specialist training so they had the skills and knowledge to meet people's needs. Staff were recruited safely.

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 were not consistently kept safe at the home. This was because the management of medicines was not consistently safe. In addition, risks to people were not consistently managed to make sure they received the correct care they needed.

There were not always enough staff deployed or employed to safely meet people's needs.

Equipment and the building was well maintained.

Is the service effective?

Requires Improvement

The service was effective but some improvements were needed. People were offered a choice of food and drinks. However, this was not effectively recorded or monitored to make sure people ate and drank enough.

Some people's pain was not effectively managed.

Staff understood the requirements of the Mental Capacity Act 2005 (MCA) and how this applied to their daily work.

People had access to a range of healthcare professionals as appropriate.

Is the service caring?

Good

The home was caring. The people told us that staff were kind and caring.

People were involved in decisions about the support they received and their independence was respected.

Staff were aware of people's preferences and respected their privacy and dignity.

Is the service responsive?

Good

Overall, the service was responsive to people and their needs.

People had personalised plans which took account their likes, dislikes and preferences.

People knew how to make a complaint.

Is the service well-led?

Requires Improvement

The service was well led but some improvements were needed. This was because some of the shortfalls we found had not been identified by the service.

Observations and feedback from people and staff showed us the service had an open culture.

Feedback was being regularly sought from people and staff.

There were systems in place to monitor the safety and quality of the service. Improvement plans were in place.

The Grange - Care Home Physical Disabilities

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.

This inspection took place on 21, 22 and 23 September 2016 and was unannounced. The inspection was conducted by two inspectors on 21 September and one inspector on 22 and 23 September.

We met and spoke with the 10 people who lived at the service and one person who was staying at the home for a short break. One of the people we met had complex ways of communicating and was not able to tell us their experiences of the service. We spoke with one visitor and a visiting employee of the provider. We observed staff supporting people. We also spoke with the manager, the care supervisor, a senior support worker, two support workers and an agency worker.

We looked at three people's care and support records and records about how the service was managed. This included five staffing recruitment records, medicine records, audits, meeting minutes and quality assurance records.

Before the inspection, the provider completed a Provider Information Return (PIR). This 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. We also looked at incidents that they had notified us about. We also contacted a commissioner, health and social care professionals and a safeguarding social worker to obtain their views.

Following the inspection, the manager sent us the provider's internal assessment of the service, the improvement plan, policies, and the staff training overview.

Requires Improvement

Is the service safe?

Our findings

People told us staff either assisted them with or administered their medicines. One person told us they were prescribed pain relief four times a day. They said they no longer needed this on a regular basis but this had not been reviewed by the GP. The person confirmed that staff managed their medicines and GP Reviews.

We checked the medicine storage and stock management systems in place for five people. Medicines were stored safely. We checked the storage and stock for some specialist medicines and found the stock and the medicine record book balanced for those medicines.

We looked at the MAR (medicine administration records) for six people. There were some gaps in the records of administration for all six people. These gaps included prescribed tablets and cream and topical lotions. For one person who was living with dementia their pain relief had not been administered as prescribed. Staff confirmed this person may not have been able to indicate when they were in pain. This meant we could not be sure that people had received their medicines as prescribed.

People did not have PRN 'as needed' medicine plans in place so that staff knew when to administer 'as needed' medicines. This meant staff did not have guidance as to when they needed to administer the medicines, the dosage, time between doses and the maximum dosage in 24 hours. In addition, there was not a consistent system for staff to record PRN medicines and different staff recorded different codes. The manager acknowledged that a consistent system was needed.

Only staff that were trained administered medicines and they had their competency assessed annually to make sure they remained competent. The manager told us and showed us records that following any medicines errors medical advice was sought and the staff's competency was reassessed.

Risks to people were assessed and planned for. However, some people did not consistently receive the correct care and support from staff as detailed in their risk management plans. The risks were increased for some people because they were not able to raise a concern or talk about their experiences. This was because of their communication needs and or because they were living with dementia. For example, one person, who was living with dementia, had a PEG (percutaneous endoscopic gastrostomy) feeding tube. This is a tube that is placed through the abdominal wall and into the stomach. Their care plan and a notice in their bedroom showed they needed to have their PEG tube rotated every Wednesday and the syringes changed every Wednesday and Sunday. The plan and notice detailed that this was to be recorded in the person's care records. For the month of September there were no records of their PEG tube being rotated and one record of the syringes being changed. The person had also had an infection in the PEG site during the previous weeks.

These shortfalls in the risk management of people and medicines management were breaches of Regulation 12 (2) (a)(b) and (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us staffing levels were calculated on annual basis based on people's needs. This annual

review did not take into consideration the needs of people who came for short stays or new admissions into the home. Additional information such as call bell response times were not reviewed to establish whether there were times when people had delays in receiving their care or support. The manager also told us that funding was not consistently available to fund people's social activities in the home and community. The manager said they were able to respond and increase staffing when people were unwell or needed extra staffing for a short period. For example, one person was discharged from hospital and they needed additional support and care until they fully recovered.

There was a core and stable team of senior support workers. However, there was a high turnover of support workers and recruitment and retention of staff was a problem. There was a high use of agency staff at the home to cover the staff vacancies and staff sickness. Short notice staff sickness had also been identified as an issue. These shifts were difficult to cover at short notice. This meant there were times when planned staffing levels were not met. The manager told us there were systems in place to monitor and support staff following any periods of sickness in an attempt to reduce sickness levels.

There were mixed views from people as to the impact of high agency staff use had on them. Most people told us that agency staff usage was an issue. One person said, "When it's (home staff) it's ok because they know what we like but having different staff isn't good". Another person told us, "some of them are very nice and I have to explain what help I need but some of them don't understand English and this can be a problem".

There were 10 staff working in the mornings and this reduced to seven or eight staff in the afternoons and evening and from 9.30 pm there were three waking night staff. The manager did not work at the weekends so were not available to support the staff as they did during the week. The manager told us following the inspection the care supervisor worked one weekend out of four and adjusted their working pattern to include evenings to ensure there was senior staff working at all times.

People told us there were not enough staff during the evenings, at night and at weekends. For example, one person said the staffing levels were having a negative impact on them. They told us, "I don't use the call bell much but sometimes I will use it at night. They (staff) come and turn the bell off and don't come back for an hour. This is because I need two staff and I have to wait for another member of staff to be available. There have been long delays when I've needed to go to the toilet and I have then had accidents".

There were mixed views from staff as to whether there were enough staff on duty. They commented that the high agency usage had an impact on staff because they needed to guide and supervise some agency staff.

The staffing shortfalls were a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe. However, one person felt the service was "over safe", they explained this was because they were not able to open the front door independently because of the door release system in use.

Staff had received training in keeping adults safe. Staff knew how to report any allegations of abuse. The manager was cooperating with a safeguarding investigation and had undertaken an internal investigation. However, we received feedback from the safeguarding team that they had needed to request further information as the investigation had not considered all of the information available. The manager confirmed they were providing the additional information requested.

Recruitment practices were safe and the relevant checks had been completed before staff worked unsupervised at the home. These checks included the use of application forms, an interview, reference checks and criminal record checks. This made sure that people were protected as far as possible from staff who were known to be unsuitable.

There were systems in place for the maintenance and monitoring of the building and equipment. This included the servicing of boilers, hoists, equipment and a legionella risk management plan.

Requires Improvement

Is the service effective?

Our findings

People who had pain from health conditions did not routinely have their pain assessed using a recognised pain assessment tool. These tools are used to assess people's pain levels if they cannot verbalise if they are in pain. People with complex ways of communicating or disabilities or who are living with dementia may not always be able to say or show when they are in pain. One person living with dementia was prescribed pain relief and the weeks before the inspection had an infection in their PEG tube site and had been unwell with a cold. The person had not been given any pain relief even though this was prescribed four times a day. We fed back our serious concerns about this to the manager and care supervisor who took immediate action to source pain assessment tools and implement them for those people who could not verbalise if they were in pain.

People's nutritional needs were assessed and planned for. People's nutritional plans were detailed and included how people liked to eat, any specific SALT (Speech and Language Therapist) plans, the consistency of their food and fluids and what support they needed to eat and drink. The risk assessments and plans also detailed how frequently the person should be weighed to monitor their weight. People told us they were supported with their food and drink as detailed in their care plans and their weight was monitored if it needed to be. However, one person, who was living with dementia and was nutritionally at risk, had a care plan that included they needed to be weighed on a weekly basis. This was important because if the person lost weight they needed to have their prescribed fortified drinks increased. However, the person had not been weighed weekly to establish whether additional prescribed supplements were needed.

Fluid monitoring records for people did not include a target amount and some were not totalled. The amounts of fluids were not reviewed to make sure that people were receiving sufficient fluids to keep them hydrated. For example, one person, who was living with dementia, received their fluids through their PEG and orally. Their nutrition plan detailed they needed a minimum of 1000mls of fluid a day through their PEG tube. However, none of the fluid records included a target amount, and most were not totalled to check whether that this minimum amount of fluids was being achieved.

These shortfalls were a breach of Regulation 9 (1)(a)(b)(c) (3)(a)(b)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had access to specialist health care professionals, such as physiotherapists, community mental health nurses, dieticians, occupational therapists, multiple sclerosis nurses, speech and language therapists and specialist consultants.

Health and social care professionals told us the service made appropriate referrals and actively sought advice for people. Specifically in relation to moving and handling, equipment and adaptations needed. One professional commented the service had made an appropriate referral for support for one person and their specific needs. They told us it was positive the service had considered this area of need for the person.

People told us each group of apartments planned their menus with staff on a weekly basis. They produced

shopping lists and ordered their shopping on-line to be delivered. One person said they frequently went to the local shops to get additional bread and milk for their group of apartments. People said they could be as independent as they wanted in relation to food, drink preparation and cooking. For example, one person said they liked to prepare their own breakfast and lunch and joined the rest of the people in their apartments for the evening meal. Another person told us they were happy for staff to prepare their meals and cook for them. Another person told us they were limited as to what they could do on the kitchen because of their disability but that staff still included them as much as possible.

The manager acknowledged that some staff had not had one to one support sessions as frequently as detailed in the provider's policy. The manager showed us the plan in place to ensure that staff received more frequent one to one sessions. Staff told us they felt supported and those that had been employed for over a year told us they had received an appraisal.

The manager sent us the training summary for the staff. Staff had received training in moving and handling theory and practical, medicines management, safeguarding, behaviour support awareness training, food safety, fire safety and infection control, emergency first aid, Mental Capacity Act 2005 (MCA), Deprivation of Liberty safeguards (DoLS), nutrition, and epilepsy and dementia awareness. Named staff had been trained in the PEG procedures for one person. There was not a specific training plan in place and this was an area for improvement.

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 Act requires that as far as possible people make their own decisions and are helped to do so when needed. We checked whether the service was working within the principles of the MCA. There was easy to read information displayed for people and staff that outlined the principles of the MCA. Most people who lived at The Grange had capacity to make their own decisions. They told us they were involved in making decisions and their consent was sought. Where people lacked mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Some people had representatives who had lasting power of attorneys for welfare who had made these decisions. The manager did not have full copies of these lasting powers of attorneys. This was important because the documents detailed what decisions the representative can make. The manager took immediate action and obtained copies of the documents by the last day of the inspection. This meant they could check whether the decisions made were in line with the individual legal powers specified.

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 MCA. The responsibility for this rested with the manager and we saw applications had been made where there was a risk people were being deprived of their liberty.

Good

Is the service caring?

Our findings

We saw good interactions between staff and people. They were chatting and were relaxed with each other and this showed us they enjoyed each other's company. Overall, people spoke highly of staff and the care they received.

Staff smiled and they were relaxed and friendly, they were kind and they treated people with patience and respect. They spoke fondly about people and told us they enjoyed the time they were able to spend with people.

People's privacy was respected and their dignity maintained. People's bedroom doors were closed when they were being supported with their personal care needs. Staff knocked on people's apartment doors before they entered and called people by their preferred names when speaking with them. People's care records were kept securely in either in their bedroom or the locked care office and no personal information was on display.

People told us their preferences for gender of carer were respected and wherever possible personal care was provided by the gender of carer they preferred.

People told us their relatives and friends were free to visit when they wanted. A visitor told us staff offered them a drink when they visited.

People told us and we saw staff provided care and support in ways that promoted people's independence. The manager told us they were also proud of how the service promoted people's independence. They gave the example of supporting people to access wheelchair clinics so people could have electric wheelchairs.

People and or their representatives where appropriate had been consulted about their end of life wishes. These were recorded and plans were in place where needed.

Good

Is the service responsive?

Our findings

Overall, people said staff responded to their care needs at the time they needed it. However, two people said that at times it took a long time for staff to respond to call bells.

There were daily recorded handovers where staff discussed with staff coming on duty how each person had been that day. The handover included a summary of people's needs and any updates or changes in their needs.

People had their needs assessed and from this a written care plan was produced. This written plan detailed how staff were to provide care and support to the person. People's care plans were reviewed annually. As identified earlier in 'Safe' and 'Effective' we identified some shortfalls in the monitoring and delivery of some people's care who may not be able to communicate their needs. It is recommended that these people's care plans and monitoring records be reviewed on a more frequent basis so any shortfalls can be identified and rectified at an earlier stage.

Permanent staff we spoke with were very knowledgeable about people and were able to describe how they communicated and what support and care they needed. They knew people as individuals, their life history and what was important to them. All of this information was included in the care plans.

People's care records included their life history, important relationships, how they communicated, their strengths, things they enjoyed and things they didn't like. People's care plans were personalised and focused on them as individuals. People told us they had been involved in developing their care plans. They said they had read and signed their care plans. Some people told us they chose to read their care records and that overall they reflected the care and support provided. One person told us they had been unhappy with the recordings staff had made and they had raised this with the manager who had addressed the concerns.

There was an activity co-ordinator employed by the provider who worked 20 hours a week and co-ordinated any volunteers and social activities at the service.

The provider had arranged for a 'Future Choices' session during the inspection that was facilitated by an employee of the provider but that was external to the home. This was a session organised by the provider to consult with people. People told us they had identified during the session some areas for improvement that included the recruitment and retention of staff, staffing levels and social activities. Some people told us the funding for some people's support in the community and social activities had been reduced by their funding authorities. This resulted in some people funding their own staff or personal assistants to support them in their social activities in the community. It is recommended action is taken to address the improvements identified by people during the 'Future Choices' session.

People told us they could raise concerns with any of the staff and manager and overall they felt confident they would sort their concerns out. People told us their concerns were addressed so they had not needed to

make a complaint. The register manager confirmed they dealt with people's concerns but did not currently record these. They acknowledged that it would be beneficial to be able to show how they had addressed any concerns raised. They said they would reintroduce the concerns records they had previously kept as this showed they were responsive to people's concerns and comments.

There was a written complaints procedure displayed in the home. We reviewed the complaints received since our last inspection. The manager had responded in line with the policy and had acted appropriately where people had complained.

Requires Improvement

Is the service well-led?

Our findings

Observations and feedback from people, staff and professionals showed us the service had an open culture. Staff and most people told us the manager and management team were approachable and listened to them. They said whenever they suggested or raised anything action was taken.

Health and social care professionals told us there was good communication between them and the home.

People had different opportunities to be consulted and involved in the home. There was an independent 'customer support advisor' employed by the provider who visited the home on a monthly basis to meet with and consult with people on either a group or individual basis. There were quarterly residents meetings and an annual independent survey. The themes people raised were isolation, social activities and complaints. As a result of the findings of the survey the 'Future Choices' consultation session had been arranged.

There had been improvements to the environment by the building of the conservatory area and decorating the communal areas following consultation with people. In addition computer tablets and other computer equipment was being provided for people.

There were communications systems in place and these included staff handovers, communication boards and books and staff meetings. Team leader meeting were held every month and were well attended. However, the manager told us support worker meetings were planned every three months. The minutes showed the last meeting was in March 2016 and that staff had not turned up for the meeting planned for the week before the inspection. The manager identified this as an area for improvement.

There were arrangements in place to monitor the quality and safety of the service provided. This included an annual review of the home by the provider's quality team and themed audits completed by the regional manager such as finances, food hygiene, nutritional needs and infection control. There were weekly and monthly medication audits completed. However, as identified in the safe section of the report these were not effective at identifying medicine shortfalls. This was because omissions and medicines errors identified during the inspection were not identified by staff at the home.

Feedback from people and our observations identified that call bells were not consistently responded to quickly. The manager told they did not review or monitor the call bell response times. This was an area for improvement. This was so that action could be taken where staff did not respond to people in a timely way or to identify any times of the day when they may not be enough staff.

The shortfalls in the governance at the home were a breach of Regulation 17 (1)(2)(a)(b)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were separate improvement and actions plans in place in response to the provider's quality team's audits, the local authority contract monitoring report, people's feedback, internal audits and the regional manager's audits. The manager told us the provider's electronic systems prompted them when they needed

to update the internal action plans. The manager said they planned to introduce a key worker system following feedback from people.

We looked at the systems in place for monitoring and learning from incidents, accidents and safeguarding. We saw these were reviewed on a monthly basis and any actions and learning from incidents was shared with staff at handovers and team meetings and or at one to one support meetings. In addition any incidents, accidents and safeguarding alerts were also reviewed by the provider's quality team via the electronic monitoring systems.

There were written compliments from professionals, relatives and people's representatives. The manager said these were shared so staff received the positive feedback.

All of the staff we spoke with knew how to whistleblow and raise concerns. They were confident that any issues they raised would be addressed.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care There were shortfalls in some people's needs and preferences being fully met and care plans were not being consistently followed by staff.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There were shortfalls in medicines management and managing risks for people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were shortfalls in the effectiveness of the governance systems

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were shortfalls in the numbers of staff employed and the staff deployment at certain times of the day.