Care Quality Commission

Eckling Grange Limited

Eckling Grange

Inspection report

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Date of inspection visit: 30 January and 2 February 2015
Date of publication: 13/04/2015

Ratings

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

Overall summary

The inspection took place on 30 January and 2 February 2015. It was unannounced.

Eckling Grange provides accommodation and care to a maximum of 60 older people. It is divided into two parts known within the service as The Grange and The Wing. The Wing provides most of the accommodation for people who are living with dementia. Some people live in nearby bungalows and are provided with a limited amount of support in their own homes.

There was a registered manager in post. 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.

At our last inspection we found the service was not as safe as it should be. This was because there were minor concerns in relation to systems for preventing and controlling infection. At this inspection we found progress had been made to improve training and to complete some checks. However, the manager had not been

Summary of findings

thorough in the audits so had missed areas where there was a risk that infection might be difficult to control. The action plan discussed with the provider's health and safety committee did not show when remedial action would be taken.

The Care Quality Commission is required by law to monitor the operation of the Mental capacity Act 2005 and Deprivation of Liberty Safeguards, and to report on what we find. The manager knew when to seek advice about imposing any restrictions on the freedom of people who may not understand the risks to which they were exposed so their rights could be promoted. However, the ability of people to make decisions for themselves had not always been assessed robustly before decisions were made about what was in their best interests. Further training had been planned to help with this.

Relatives valued the way that staff understood and supported people who were living with dementia. They were able to respond to agitation or distress and offer reassurance. People's health was monitored and advice taken from health professionals where this was needed. However, people's views about the way they were treated were variable. Some felt that staff were very good, caring and kind. Others did not feel they were treated kindly and with respect by staff who had not taken time to get to know them.

On occasion staff found it difficult to respond to people's requests for assistance in a timely way and people's dignity was occasionally compromised. Not everyone who was able to participate was supported and empowered to develop their plans of care. We have made a recommendation about involving people in decisions about their care.

The staff team did not all feel they were treated fairly or that there was an open culture where the manager would listen to their views. Some staff expressed concerns about working with other colleagues. We have made a recommendation about equality, motivation and team building.

We found that the provider was in breach of three regulations. Sometimes people did not receive the medicines they needed. Care and treatment was not always provided in a safe way. This was because quality monitoring systems did not adequately assess and manage risks to people and take into account the way people's records were maintained. The registered persons had failed to notify the Care Quality Commission without delay of specific events they are required to tell us about. You can see the action we have told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe.

Risks to people's welfare associated with cleanliness and from 'pinch points' for staff at peak times of day had not been properly evaluated. People did not always receive their medicines when these were needed.

People were kept safe by staff who recognised signs of potential harm and knew what to do if concerns arose. Staff used effective techniques to reduce their agitation.

Requires Improvement

Is the service effective?
The service was not consistently effective.

People received support from people who were well trained although they did not always understand how to support people with making informed decisions about their care so that their rights were protected. The manager had recognised this and was arranging further training in the Mental Capacity Act 2005.

People were supported to eat and drink enough to meet their needs and to see health professionals such as their doctor, when this was necessary.

Requires Improvement

Is the service caring?
The service was not consistently caring.

Staff spoke with people politely, offering people warmth, encouragement and reassurance. However, they did not always attend to people's needs in a way that promoted their dignity. People who felt able to participate were not always actively involved in making decisions about their own care.

People's friends and family were made welcome in the home.

Requires Improvement

Is the service responsive?
The service was not consistently responsive.

Some people's experience was that staff did not know them well and they did not know how their care had been planned. Other people had been involved but practice was variable.

People enjoyed the activities that were available. They and their relatives knew they could complain if they had any concerns although they were not always clear who they should go to.

Requires Improvement

Is the service well-led?
The service was not consistently well-led.

Requires Improvement

Summary of findings

The registered manager had failed to tell us promptly about some events in the home which must be notified by law.

Systems for monitoring the quality and safety of the service were not wholly effective in identifying where improvements needed to be made.

The culture within the home was not transparent and open. Some staff felt they would not be listened to if they approached the management team and that they were not treated fairly.

Eckling Grange

Detailed findings

Background to this inspection

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

The inspection took place on 30 January and 2 February 2015 and was unannounced. The inspection team on the first day of the inspection consisted of the lead inspector 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. A second inspector assisted on 2 February 2015.

Before our inspection we looked at all the information we had available about the home. This included the report from our last inspection, the provider's action plan and notifications made to us. Notifications are changes, events or incidents that providers must tell us about by law. We used this information to decide what we were going to focus on during this inspection.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. In addition to this we toured parts of the home and looked at what was happening for people.

We discussed the home with ten people living in the home and six of their relatives. We spoke with the registered manager, the deputy manager and eight members of the care team. We also spoke with two activities coordinators, seven other ancillary or support staff and a visiting occupational therapist. We reviewed care records for five people, 16 medication records, staff records and records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection of the service on 27 June 2014, we found that many staff were not trained in infection control and that the manager did not make checks to ensure that people were protected from the spread of infection. The manager sent us an action plan on 20 July 2014 showing how these shortfalls would be addressed. This told us that a comprehensive audit of infection control would be developed and implemented and that training for staff would be completed by the end of October 2014.

The manager had carried out a partial check since that inspection and identified that some taps had corroded so there were rough surfaces where bacteria could accrue. She said she was trying to source a less damaging cleaning product before taps were replaced but had not yet sourced a suitable product. Some flooring was damaged in communal bathing or toilet facilities so it could not be properly cleaned. For example, there was a hole in linoleum where a toilet had been moved or replaced leaving wooden floor boards exposed. The manager said this was due for replacement.

Some other areas presented an identifiable risk to people's safety and welfare and there was no plan for addressing these. For example, a bath seat had peeling paint and we found handrails next to a toilet that had cracked surfaces and rusty patches. Urine bottles stored within a sluice area were heavily stained and did not smell clean. Toilet brushes were stained brown and sitting in holders containing brown, offensive smelling water. The audit completed in September and October 2014 had not identified some of these problems and how risks to people's safety from infection should be managed. The audit only provided for checks on five of the bedrooms and had not been repeated to provide for a full or 'rolling' assessment. The concerns that had been identified in the audit had been referred to the provider's health and safety committee but did not have timescales agreed for remedial action.

We found that the registered person had not effectively assessed and monitored the quality and safety of the service that people received. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have referred our findings to the Infection Prevention and Control Team.

Hand sanitizer units were available throughout the home to assist in the prevention and control of infection. We saw that staff used these when they were moving between different areas of the home to help contribute to reducing the risk of infection. We found from records that one person had been cleared of MRSA infection while at the home. Staff confirmed they had received training in infection control and we saw a member of the care team cleaning a bath after they had assisted someone with their personal care. During our visit, some carpets were shampooed and there was a schedule showing what cleaning activities had been undertaken so that all areas of the home were included. Staff had access to protective gloves and aprons when they were delivering personal care for people so that they could protect themselves and others from infection.

The laundry area was well maintained. Dirty laundry had been correctly separated from clean laundry. Laundry was washed on the correct cycles, including the use of a sluice wash for soiled linen. This helped to reduce the risk to people of infection spreading because clean linen was less likely to be contaminated by soiled laundry.

Medication administration record (MAR) charts showed that medicines given to people were properly recorded in most cases. However, there were some gaps in recording the use of prescribed lotions and creams. MAR charts for three people showed that they had not received their morning medication because they were asleep. There was no indication that staff returned to offer these medicines later in the morning when people were awake. One person had missed a dose of their medicine because it was out of stock. This meant that, on these occasions, people did not receive their medicine as prescribed. Three people were given their medicines in either food or drink, by agreement with the GP. However, there was no evidence that the pharmacist had been consulted to ensure that the effectiveness of the medicines involved would not be impaired by such treatment.

We found that the registered person had not ensured systems for the management of medicines were safe. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In The Grange we found that the amount of one controlled medicine did not tally with the stock balance. These medicines had also been recorded as being returned to the

Is the service safe?

pharmacy on 22 October 2014 but remained within the controlled drugs cupboard so they could have been misused or misappropriated. The manager confirmed to us in writing after our inspection that the anomaly had been accounted for by a recording error and that medicines had been returned to the pharmacy for safe disposal.

One person told us, "My medication is always there when I need it." A relative commented that the person's medicines were given on time. The deputy manager was able to show us records of staff training and how the competence of staff was assessed to ensure they were able to administer medicines safely. Records also showed how staff were retrained and supervised if they made medicine errors. Staff had access to guidance about medicines prescribed for occasional use. This included what the medicine was for and when it was appropriate to administer it.

We received conflicting information about whether staffing levels were always sufficient in The Grange. One person said, "I cope well and am independent and need less support so to me, the staffing is fine." Another person told us, "I am an independent person so I get on with it. I do see issues arising in the morning in relation to staffing. My friend waited 30 minutes on her bed for someone to dress her because staff were all occupied." Staff identified difficulties in responding to people promptly at specific times of day. One said, "Morning is a real pressure time for all of us. It is hard to get certain people up at the right time. They have set times but often don't want to get up. Then we might not be available to help them at the time they want." Staff in The Grange felt that there were enough of them to meet people's needs when shifts were properly covered. They told us that staffing levels had been more consistent during the month leading up to our inspection. Staff in The Wing told us they felt staffing levels were stable and enabled them to meet people's needs properly.

During both days of our inspection and in both parts of the home, we saw that staff responded to people promptly and delivered care to people in an organised manner. We noted that staff took time to have conversations with people, to ask how they were or whether they needed anything.

We reviewed call bell logs from the provider's electronic monitoring system for two weeks selected at random to check the information we were given about demands on staff in the morning. We found that there were numerous occasions from 8am when it had taken more than ten minutes from the person calling for assistance until the call was cancelled. On some occasions the record indicated that calls were not cancelled for over half an hour. There was no analysis of 'pinch' points or patterns to determine if staffing levels should be adjusted, whether the management team should provide additional support at this time, or whether staff deployment had been a problem.

People told us that they felt safe living at Eckling Grange. One said, "I wasn't safe in my own home but here I feel very secure." Another commented, "This is a safe place for everyone." A relative told us about the person they visited. "My [relative] is totally 100% safe here. It is very reassuring." Another visitor told us what they thought about The Wing. They said, "I am comfortable with the fact my [relative] is totally safe in this unit."

Staff were clear about the need to report any concerns that people may be being abused. They told us they would report to more senior staff but also knew where to find information about contacting the safeguarding team. One staff member also told us about the support the team in The Wing had from the local Dementia Intensive Support Team. They said that this had helped them to understand how dementia impacted upon one person's behaviour and given them strategies to help offer reassurance and support so that events did not escalate.

The manager was able to tell us about the checks that were made when new staff were recruited. We checked records for three of these staff. They showed that appropriate checks were undertaken to ensure staff appointed were suitable to work with vulnerable people.

Risks to people's health were assessed. This included risks associated with poor nutrition, vulnerability to pressure ulcers and changes in mobility. A relative told us that, "They're very hot on carers working in pairs when they are lifting people." Senior staff told us about checks they made for injuries if someone had fallen, so that they would not make injuries worse by moving the person. They were also aware of the 'falls clinic' and how people could be referred for specialist advice if this was needed.

We reviewed records to do with the maintenance of the service and saw that there was regular servicing in place. This included maintenance of the fire detection system, electrical wiring, the gas cooker and hoists to ensure these were safe and working properly. The home had a 'back up' generator for use in an emergency if the power failed. Staff

Requires Improvement

Is the service safe?

also told us how they responded to emergencies such as a fire breaking out and confirmed they had training in this so that they would know how to support people in an emergency.

Requires Improvement

Is the service effective?

Our findings

People told us, "The staff seem well trained." A visitor to the home said, "I know training goes on because I see new staff accompanied by experienced ones." A staff member commented that, "Management is fully behind me developing and getting training." Another said, "My training is smack up to date." One senior staff member working in The Wing said that they were to commence specialist training in dementia care so that they could help staff to develop further and improve care. We observed that staff in The Wing responded appropriately to people who were becoming anxious or agitated and eased this by offering diversion, distraction and reassurance. All of them felt that their training helped them to meet people's needs appropriately.

Staff said that they received supervision from more senior members of staff so that they were supported in their roles. One staff member was trained to deliver moving and handling training so that staff remained competent in this area. A visiting health professional felt that staff acted upon their advice to meet people's needs. Staff were able to tell us about the needs of people they were supporting. We concluded that staff had the knowledge and skills they needed to carry out their roles.

One person told us, "Carers always ask for permission before doing anything to you." We reviewed care records in The Wing and noted that assessments of people's capacity to make decisions about their health and welfare had been completed. However, these recorded the assistance people needed from staff to complete an activity, such as having their medicines or receiving personal care. They did not show how information had been presented to people in a way that would help them to understand and make decisions about their care before any conclusion was drawn about their capacity.

We found that some people were receiving their medicines covertly as this had been considered to be in their best interests after discussion with their GP and family members. However, a robust assessment of their capacity had not been completed first to see if they understood the implications of refusing medicines. We also noted that records showed where people's relatives had a 'lasting power of attorney' (LPA). However, they did not distinguish whether this was just for finances or also with regard to decisions about health and welfare. Some staff spoken with were unclear that there was a difference. The manager had recognised that supporting people with appropriate decisions needed to be improved and showed us that further training in the Mental Capacity Act 2005 had been arranged for the staff team. The manager understood when applications needed to be made under the Deprivation of Liberty Safeguards to ensure people were not unreasonably restricted and their rights were protected.

Everyone spoken with felt there was enough food and the majority of people or their relatives were satisfied with the quality. For example, one person said, "We get plenty of food and the choice is OK." One told us that there was a vegetarian option if this was required and another said, "The food is well cooked with a good choice and it's good quality." A relative also told us, "The food is good and I can say that with confidence as I have eaten here. I support my [relative] with food and drink if I'm here but I know they help her if not." Another relative said, "The food is excellent. The relatives can eat with people, which is nice."

This contrasted with other comments from four people spoken with who felt that the quality of meals had declined. For example, one person told us, "The food is OK. When you do things in bulk it's not going to be tasty. Another commented, "There's plenty of food but the quality has gone downhill. They seem to be cutting back." They gave the example of Boxing Day when they said there was usually a really nice tea but that there had been no celebration tea last time. "The food could be a lot better. It is very basic and much the same. If you don't like the options at lunch time you can have soup or a baked potato. They don't drain their vegetables properly so they are full of water and very soggy. They are not nice at all." The manager did not feel that any changes had been made to food supplies or meal options that would support a decline in the quality of meals. There was no evidence at inspection that vegetables were not properly drained. Food smelled appetising and we observed that people ate well.

We saw that people needing their meals pureed because of difficulties eating, were presented the items pureed separately so they could taste and smell the different components. Most staff assisting people to eat kept the meals this way so people could experience different tastes and smells. However, we saw that one staff member did scoop the meat and vegetables together while they were assisting so that the person was presented with a brown, uniform meal of unappetising appearance.

Requires Improvement

Is the service effective?

We saw that people were assessed to see if they were at risk from not eating or drinking enough, and information showed how they were to be supported to minimise this risk. During lunchtime in The Wing we saw that people received the assistance they required to eat and drink. Others were prompted and encouraged. People were offered a choice of food and the menu was displayed. Staff were clear about the need to 'fortify' food for some people to increase their calorie intake and information about this was contained in care plans. In the main dining room in The Grange we saw that people with a larger appetite had extra potatoes and vegetables available to them in small metal dishes with lids. Mealtimes in both The Wing and The Grange were unhurried and with a calm atmosphere.

People told us that staff supported them with their health care and staff would arrange appointments for them if it was needed. One person said, "I know if I requested a doctor or whatever, they would respond." A relative told us they felt that staff had acted promptly in relation to obtaining medical care. "They spotted that her hearing aid was damaged and sent it straight off for repair. Another said, "I have had to ask for something to be done that was not picked up, but to be honest, that was a one off."

People's records showed that they were referred to the doctor when they were unwell. There was also evidence of support from the optician, dentist, occupational therapist and district nursing team. An occupational therapist told us that people were referred appropriately and that staff acted upon the advice they were given. Specialist advice regarding dementia had also been obtained where this was considered necessary to promote someone's emotional wellbeing.

Requires Improvement

Is the service caring?

Our findings

One person living in the home told us, "The staff are a nice bunch. They work hard and support us as best as they can." Another person said, "I find the staff respond the more social you are. They are wonderful people here." A relative commented, "Staff speak in a friendly and respectful way to residents and there is a caring relationship." Visitors to people living in The Wing were particularly complementary about staff. One said, "The staff are so kind in this unit. I've had a lot of experience of life but I've never met a more caring, decent bunch." Another commented that "Overall, there is a personal approach here with respect shown for residents. The dementia unit is a lovely, lovely environment with carers who are gentle and kind. It is a comforting place for my [relative] and me."

However, most people who commented about staff attitudes did not feel that staff took the time to get to know them properly. For example, one person said, "The staff do what they need to do. I can't say they are especially nice." Another commented, "No, the staff overall are not really kind or friendly for that matter. Of course, some are. They could take more interest in me as an individual, but I suspect they are just too busy." A third person said, ""Most of the staff are very nice. There's the odd one or two that aren't but you get that everywhere."

People were able to make choices about whether to join in activities, what to eat and wear, and where to spend their time in the home. One visitor told us they had been involved in developing the care plan with staff, in support of their relative who was living with dementia. Another commented, "My [family member] came here last October. We were fully involved in their care planning." Others were less clear and the practice of involving people or their relatives in making decisions about their care was inconsistent. One relative said, "What is this care plan? I don't know about that." Another told us, "I am not aware of any care plan at all and, as I have power of attorney, I presume anything like that would involve me." One person living in the home told us they had not been involved in contributing to assessing and planning their care. Another person said, "I have no idea whatsoever what a care plan is." We concluded that people were not consistently supported to express their views and empowered to plan their own care.

We observed that some staff found it easier to engage with people who were more able to communicate verbally. For example, one staff member assisting a person to eat had limited interaction with the person they were supporting. They maintained a conversation either with another person who was sitting further away, or a colleague. When they engaged with the person they were supporting this was largely task focussed, consisting of prompts while they assisted the person to eat their meal. We also saw that during the morning one person had no interaction with staff at all for a period of half an hour when they were sitting in the corner of a lounge.

We noted examples of two people's dignity being compromised. In one case a staff member asked someone in quite a loud voice in front of others, whether they wanted to go to the toilet to "…see if you need to do anything." Another person asked the chef in the dining room of the Grange if they could be assisted to the toilet. The chef passed this information on to the staff member who was administering the medicines. They asked the person to wait to be assisted. For the following 15 minutes, a number of staff walked past the person and none of them was asked to assist. The person became increasingly anxious so the inspector asked a staff member to assist.

From this we concluded that not everyone received support in a way that was consistently caring and respectful.

Two people felt that they weren't always treated with respect for their dignity. One said that staff did usually knock on their door but this was not always the case. Another said, "They tend to bang on the door and then just come into my room without announcement." While we were present we saw examples of staff respecting people's privacy showing that they were aware of good practice. After knocking they opened doors a fraction to see if they could go in. People felt that staff were respectful of confidentiality, being discreet and not talking about other residents in front of them. People's records were held securely so that information about them was protected.

The home is based on a Christian ethos and some people said they liked the opportunity to join in the spiritual events because of their religious beliefs. People in the main dining room joined in with saying a prayer before their lunch and one person being assisted to the dining room lustily joined in hymn singing with a staff member. A staff member confirmed they had training in equality and diversity. They

Requires Improvement

Is the service caring?

told us that it was important not to discriminate against people they were supporting and they would report this as a safeguarding concern if they felt a person was treated unfairly. One person living in the home told us that they felt they were fairly treated by staff.

People's family and friends were able to visit and one person's family was staying in the home with them because they were so unwell. Visitors told us that they were made welcome by staff and throughout our inspection we saw that family members came to spend time with people.

Levels of agitation or anxiety were low and staff responded to people calmly and promptly when people did become distressed. When one person did become anxious, a staff member gently put an arm around them, found out what was bothering them and acted to address it promptly. Another person was offered a drink and reassurance by a staff member. The staff asked them if they would like tea or coffee and then told the person, "Don't worry. I will get it for you then come and find you." We saw that they did so, guided the person to a comfortable seat and sat with them while they drank and ate a biscuit, chatting to them throughout. The person did not respond verbally but did smile at the staff member. We observed another staff member assisting someone with their meal. Although the person did not communicate with them verbally, the staff member spoke to them about the food, what was going on in the home and encouraged them with their eating. They made eye contact with the person who did smile at them.

We saw that staff encouraged people to do what they could for themselves. A visitor also commented about the way staff encouraged the person to be independent. "She is encouraged to stay as active as possible and a member of staff was encouraging her to walk down the corridor when it would have been easier for them to take her in a wheelchair." Staff recognised the importance of doing this. One told us, "I always encourage people to be independent." They gave us the example of one person they encouraged with their eating. "I encourage her to have a go. It's slower but better than feeding her myself."

We recommend that the service seek advice and guidance from a reputable source, about supporting people to express their views and involving them in decisions about their care, treatment and support.

Requires Improvement

Is the service responsive?

Our findings

We reviewed care records and these showed that some people had signed their care plans to show they had contributed to the assessment and planning of their care. Others had not. This included people where there was no indication they lacked capacity to plan their care. One person said, "I am not involved in my care plan although I am 'with it' enough to do so." There was a recording form for showing how relatives were involved in reviews of people's care plans. These said they were for completion every three months but in one case, there was nothing to indicate this had happened since June 2014.

However, we noted that this person's plan of care had been reviewed by staff when their needs had changed. Staff were able to tell us about the reason for this and told us they felt that care plans conveyed a good picture of people's needs. One staff member told us, "I get to know residents by talking to them and also we have a care plan that is informative." Another staff member said, "The care plans convey a very true picture. They are read and updated." We saw that one staff member supported someone talking to them very quietly. Another member of staff told us that this was the person's preference. We reviewed the person's care plan which showed they did not respond well to staff who they perceived as overly loud or excitable. We concluded that staff were aware of that person's individual needs and how best to support them.

However, we noted other inconsistencies in care records indicating planned care had not been delivered to address individual needs. For example, one person's care records showed an assessment of pressure area vulnerability and recorded the action that, because the person was also at high risk of poor nutrition, they should be weighed weekly. This assessment was made on 15 July 2014 but the person continued to be weighed monthly without this being identified as a shortfall in their care. A meeting with the person's family took place in December 2014 and the record of this showed a programme of weekly weights had been agreed at the meeting so the person's health would be monitored. This should have been actioned five months previously in response to the assessment in July.

People valued the opportunities they had for activities. One person said, "There are things going on and we can get together for activities like exercise. We've even had carpet bowls in the big lounge." Another person said, "I knit and play Scrabble and do craft things." A relative commented that the person they visited had hand massage therapy. They said, "Things are on offer – it's down to residents choosing whether or not to participate." An activities coordinator told us how they got to find out what activities people enjoyed through talking and asking, as well as discussing people's interests with relatives.

In The Wing we saw people engaged in a 'parachute' activity, trying to keep a foam ball on a large brightly coloured cloth without it falling off the edge. People were smiling and laughing during this as well as exercising their arms. Later on we saw that a word game was in progress and the activities coordinator also used this to engage people in reminiscing about their school days. In the Grange we saw some people playing Scrabble. Others were clearly enjoying the experience of having their hair done and being pampered. There were dedicated staff members in both The Wing and The Grange to offer activities for people and a programme of these was displayed.

People were confident that their concerns and complaints would be addressed. One person said, "They would take notice of me if there was something really wrong and in that case I would find someone in the office." Another said, "The staff respond if I need something and they would probably spot that anyway. I grumble and let people know if I'm not happy. I don't like things to fester." One person told us "I think there is a lady in charge here so she is the one I would need to speak to if I was really unhappy about something. I feel they would listen to me and act on my concerns." Staff were clear about their responsibility to ensure concerns raised with them were addressed promptly if possible or referred onwards. However, there was some confusion from people and relatives about who they should go to with complaints. Two people identified the home as being run by a man (the general manager), when the person in charge of care and registered as the home's manager, was a woman. A visiting relative said, "I'm confused as to whom I'm supposed to raise issues with. It's got this open door policy but which is the door?"

Requires Improvement

Is the service well-led?

Our findings

During our discussions with staff and the manager, we identified that people had experienced pressure ulcers of grade 3 or above. Records for one person showed that they had a pressure ulcer of grade 4 identified in October but the Care Quality Commission (CQC) had not been told for two weeks. A second person had a grade 3 pressure ulcer recorded in their notes on 22 January, 11 days before we identified this at inspection. This had not been notified to CQC. We discussed this with the registered manager and deputy manager who told us that they thought the 'Datix' system used by district nurses would notify us of such conditions. The registered manager had failed to make the appropriate notifications without delay.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Quality assurance systems were not effective enough to ensure improvements were made and sustained. For example, the infection control audit from September and October 2014 had not been updated or extended with a robust action plan for addressing areas of risk. This was the only check on cleanliness since May 2014 when we asked the manager to complete an audit as a result of a complaint received by us. Controlled drugs remained in the building more than three months after records indicated they were being disposed of. The management team told us this was because they were waiting for a specific record book. The anomaly in there being more of this medicine than had been recorded had not been identified and investigated until we required this at inspection.

Audits and checks were insufficiently robust to ensure that records were properly maintained and to identify shortfalls. For example, two people at high risk (or with) pressure ulcers had repositioning charts in place, but there were significant gaps in records which had not been identified. Staff said that they did reposition people but had forgotten to complete the charts.

One person's body chart, completed on 3 December 2014 showed they had bruising to their outer hips and upper right thigh. Skin discolouration in their groin area had been attributed to issues with a continence aid. However, no investigation had been made about the circumstances of the other bruising, for example, to ensure moving and handling practices met the person's needs safely.

We found that the registered person had not effectively assessed and monitored the quality and safety of the service that people received. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's visitors told us they had been asked for their views in a questionnaire. One visitor told us how staff on duty checked with them whether they were satisfied with their relatives care. Although some people using the service could not remember being asked what they thought about it we saw that findings of surveys had been analysed to see what could improve. However, the intentions for improvement had not been well communicated to all parties. Two relatives commented to us that they had completed a questionnaire but they were not aware of any changes or improvements that had been implemented as a result of this.

From our discussions we concluded that staff did not feel that the management team understood the pressures they were under. One said, "Management needs to get out there and experience what we do. After a rushed morning I am exhausted. I would respect them if they just had a go for half a day. It would change their opinion." A relative also commented, "I have a hunch and it's this. There are actually plenty of people floating about managing the place and filling in all the necessary paperwork. They need to be certain what's going on out there where the caring is going on." Staff also told us that the manager and deputy were not always 'visible' in the home and tended to spend most of their time in the office. One person living in the home also told us that they hardly ever saw the management team.

We received feedback from some staff during our inspection that they felt the manager and deputy manager were approachable. However, most of them told us they would go to their heads of care rather than the manager or deputy. They said they felt that the management team did not ask them what they thought and were not confident their views would be properly considered. Three staff told us they did not feel valued or well treated by the management team because they felt they were belittled.

Staff did not consistently feel that they had access to equal and fair opportunities to progress their career. One told us that some staff were favoured and 'groomed' for promotion

Requires Improvement

Is the service well-led?

and a lack of fairness. This was also raised with us after the inspection visit where anxiety was expressed about the numbers of family and friends employed by the management team. Staff said that they felt that this meant concerns about staff conduct were not always dealt with fairly so some staff would be heavily criticised if they made a mistake and other issues would be swept under the carpet rather than being addressed. One staff member also commented about team work overall. They felt that older staff resented newer ones and did not see any need to change their practice. They said, “There are some staff I am not so keen to work with.”

We recommend that the service seek support and training, for the management team, about equality, motivation and team building.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes were not operating effectively to assess, monitor and improve the quality and safety of the service. Risks to health, safety and welfare were not properly assessed and monitored and records in relation to care and treatment for people were not maintained as accurate and complete. Regulation 17(1), (2)(a), (b) and (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not protected against the risks associated with medicines. Arrangements for ensuring they were obtained, administered as prescribed, recorded, accounted for and disposed of were not robust. Regulation 12(1) and (2)(f) and (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered person had not notified the Commission without delay of all relevant events happening in the home and affecting people living there. Regulation 18(1) and (2)