EHC Moston Grange Limited

Moston Grange Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place over two days on 26 March and 27 March 2018. The first day was unannounced, which meant the service did not know in advance we were coming. The second day was by arrangement.

Moston Grange Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. Moston Grange Nursing Home is owned and operated by EHC Moston Grange Limited, trading as Equilibrium Healthcare, and is registered with CQC to accommodate up to 64 people. At the time of this inspection, 48 people were living at the service.

Accommodation is arranged over five units; Deanvale, Mapledene, Woodside, Hollybank View and Hollybank Vale. Nursing care is provided to people living with various forms of neurological disorder such as dementia, acquired brain injury and other forms of degenerative mental health disorders.

We last inspected Moston Grange Nursing Home in July 2017. At that time, we found breaches of legal requirements and the home was rated 'requires improvement' in all areas. We also took enforcement action by serving three warning notices in respect of safe care and treatment, safeguarding people from abuse and improper treatment, and good governance. We had scheduled a date to return back to Moston Grange to check on progress. However, in the intervening period since our last inspection, CQC received information of concern that was of a safeguarding nature. In response to this, we raised a safeguarding alert with the local authority and brought forward the scheduled inspection. We also shared these concerns with a senior manager from Equilibrium Healthcare so that immediate action could be taken to ensure people who used the service were safeguarded. However, these matters had been fully investigation by the provider and none of the allegations subsequently resulted in any formal disciplinary sanction being issued against staff.

At this inspection we found the service had failed to make sufficient progress or achieve compliance in respect of the three warning notices issued following our last inspection. This meant there was a continuing breach of regulations and a failure to act on past risks that were already known to the service provider. We also made a recommendation following this inspection with regards to equality and diversity. We are currently considering our enforcement options in regards to these continuing breaches. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

During a tour of the premises, we found people who used the service were exposed to a risk of harm caused through the inappropriate storage of equipment in a communal bathroom, a storage cupboard with a broken lock that contained razor blades and medicinal creams, and a sluice room containing hazardous substances that had been left unlocked.

We found continued failures in respect of the delivery of safe care and treatment and how risks to people who used the service were identified and mitigated. In particular, risks associated with the management of people with complex needs, those deemed at a high risk of malnutrition, and those at risk of pressure sores.

The safe management of medicines was not consistent across the service. We found inconsistencies in recording when a PRN (as and when required) medicine had been given, the medicine round on one unit took an extended period of time to complete, which meant people were at risk of not receiving their medicines in a timely manner or as prescribed and medicines competency checks were not always completed with staff who had responsibility for the management and administration of medicines.

Aspects of the home were found to not be visibly clean with waste bins overflowing and food waste from breakfast remained on the floor throughout the first day of inspection. In one person's bedroom we also found their wall to be partially contaminated with Enteral feed that had splashed back onto the wall but then left unattended. Enteral feed is presented in liquid form of a nutritionally complete feed.

We were not assured that systems and process for safeguarding people who used the service from abuse were operated effectively. This was because a safeguarding incident had previously occurred which management had no awareness of because there had been a failure by staff to follow the procedures. This meant there had been no investigation and the alleged perpetrator was left without challenge.

At the time of our inspection the home was dependent on the use of agency staff. In part, this was related to ongoing disciplinary matters within the home which meant a number of staff were not available to work. We found the provider was seeking to address staffing shortfalls in response to ongoing recruitment and retention issues. However, the deployment of existing staff was not effective and registered nurses did not always feel sufficient operational support was provided.

Aspects of the service were not operated in line with the principles of the Mental Capacity Act (2005). On Mapledene unit, we found inherent restrictions were placed on people's freedom of movement. Staff told us this was because they could not always assist people in a timely manner because of people's dependency and the fact many people were wheelchair users. Staff also told us limitations on space on the unit meant they needed to 'stagger' when people could be brought out of their rooms. However, this was at the discretion of the staff and not through choice of the person who used the service.

We received a mixed response from people who used the service in respect of the meal time experience. However, we found people were offered choice from a daily menu and people could choose to eat in the communal dining area or in their own room.

Improvements had been made to the overall format of care and treatment records but we found inconsistencies in the quality of information being recorded. Evaluations of care were also not always completed when a change had occurred.

Throughout the inspection, we observed numerous examples of positive and caring interactions between staff and people who used the service. However, opportunities for such interactions were limited as staff primarily focused on the delivery of task based care.

Systems and processes for audit, quality assurance and acting on feedback from people who used the service were not operated effectively.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures.' Services in

special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, it will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe, so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This may lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This may lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People who used the service were exposed to a risk of harm through hazards associated with the building and premises.

Risks associated with the delivery of safe and effective care had not been mitigated. In particular for people living with complex needs.

Aspects of the service were visibly dirty and people's communal living spaces were showing signs of wear and tear.

Is the service effective?

Requires Improvement

The service was not effective.

The 'whole service handover' at staff shift change was not operated effectively which meant key information concerning people's care needs was at risk of being missed.

Access to suitable outdoor space was restricted in some areas of the service due to delays in repairs that were required to make the area safe.

Staff told us they considered there to be sufficient opportunities for training and on-going development.

Is the service caring?

Requires Improvement

Aspects of the service were not caring.

Feedback provided by people who used the service was not always acted upon which meant there was a continuance of issues.

The effectiveness of the service providers approach to equality and diversity was not evidenced at a local level with regards to positive outcomes for people who used the service.

On three units we observed staff engage with people in a caring manner but this was not evident on Mapledene.

Is the service responsive?

Requires Improvement

The service was not responsive.

There was an unacceptable level of variation in the quality of information being recorded in people's care records and the timeliness in which evaluations were completed.

Despite previous assurances about the services approach to engaging people who used the service in person-centred meaningful activities, this had not been embedded into the service and development work was still on-going.

People who used the service and visiting relatives told us they knew how to make a complaint.

Is the service well-led?

Inadequate

The service was not well-led.

The service has consistently failed to achieve compliance with legal requirements since 2016.

Systems and processes for audit, quality assurance and questioning of practice were not operated effectively.

The service provider had failed to act on areas of risk that were already known to them.

The effectiveness of the new management structure was yet to be evidenced and considerable further improvement work was required.

Moston Grange Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place over two days on 26 March and 27 March 2018. The first day was unannounced, which meant the service did not know in advance we were coming. The second day was by arrangement.

A planned inspection of Moston Grange Nursing Home was brought forward in response to information of concern received by the Care Quality Commission (CQC). These concerns were of a safeguarding nature.

The inspection team comprised of four adult social care inspectors and an assistant inspector from CQC 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.

Due to the timeframe in which this inspection was completed, a Provider Information Return (PIR) was not requested to support us with our inspection planning. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. However, we reviewed information we already held in the form of statutory notifications received from the service, including safeguarding incidents, deaths and serious injuries.

Due to the nature of the service provided at Moston Grange, some people were unable to share their experiences with us; therefore we completed a 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 spoke with 12 people who used the service and three visiting relatives.

We also spoke with 10 members of staff, including the operations manager, clinical nurse leads, quality assurance manager, human resources manager, four registered nurses, support workers, senior support workers and the activity coordinators. We also spoke with a visiting professional from a local authority.

We looked in detail at 13 care plans and associated documentation; six staff files including recruitment and selection records; training and development records; audit and quality assurance; policies and procedures and records relating to the safety the building, premises and equipment.
We also reviewed records relating to the management of medicines across each of the five units.

Inadequate

Is the service safe?

Our findings

At our last inspection of Moston Grange Nursing Home in July 2017 we identified a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to a failure to provide safe care and treatment. In response to this, we took enforcement action by serving a warning notice. At this inspection we found a repetition of the concerns we had previously raised which meant the service had failed to comply with the warning notice.

During our inspection, the vast majority of our concerns were centred on Mapledene unit. In particular, concerns in respect of the delivery of safe care and treatment and how risks to people who used the service were identified and mitigated.

We reviewed the care records of one person who had a Percutaneous Endoscopic Gastrostomy (PEG) in place. A PEG is an endoscopic medical procedure in which a tube (PEG tube) is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding and administering liquid medicines when oral intake is impaired. In the section of this person's care plan relevant to diet and nutrition, we found basic information was recorded relating to the fact this person had a PEG insitu but this did not provide sufficient detail with regards to the safe and effective daily management of the PEG. For example, no information was provided with regards to the prescribed plan of feed and water flushes; there was no information with regards to safe positioning in bed; and no information about the management of the PEG site including cleaning and wound management, this was despite a previous infection to the PEG site. We also found this person had been left without their Enteral PEG feed for a period of 22 hours and we were told by staff this was due to issues related to the pharmacist and insufficient stock. However, we found no contingency plan was in place to mitigate against such an occurrence. This person was also dependent on supplementary oxygen but we found no oxygen care plan and staff told us there was confusion with regards to the method of delivery and the number of litres of oxygen per minute this person required.

We also reviewed the care records of a person who had been assessed as a high risk of malnutrition due to recent weight loss. We found there had been a delay of eight days before any formal monitoring of their food intake had commenced. During late afternoon on the first day of our inspection, we also saw that this person still had a full plate of untouched food from lunch time and it appeared no assistance had been provided by staff. This was despite this person having a well-documented history of behaviours that challenge which included a reluctance to eat. However, no information or guidance was provided for staff which gave direction as to how this person should be supported physically or verbally at meal times to prevent further weight loss.

In respect of a third person, during our discussions with their relative, we were told they had developed a sacral pressure sore. We therefore reviewed this person's care records and found a pressure sore risk assessment dated 14 March 2018 which indicated this person to be a high risk of developing pressure sores. However, we found no pressure sore care plan had been formulated or associated guidance for staff which sought to ensure an appropriate level of care and treatment would be provided and that any risks associated with developing a pressure sore in the future had been mitigated. However, since this person had

been assessed as a high risk, records demonstrated this person was supported with pressure relief on a four hourly basis when either sat in their chair or lying in bed.

When looking at the management of medicines at Moston Grange, we found areas of concern on Hollybank View, Hollybank Vale and Mapledene in respect of 'PRN' (as and when required) medicines. We found inconsistencies in recording when a PRN medicine had been given. For example, the reason for administration was not always noted in the medicine notes or care plan. This meant for those people who had PRN medicines prescribed, there was no accurate way of ascertaining if a PRN medicine had been given in response to a particular clinical concern. For example, a person presenting with signs of a raised temperature or expressing they were in pain. This meant clinical oversight was not always being maintained to determine whether medical assessment was required.

On Mapledene we observed the morning medicines round commenced at 08:30am and was not completed until 11:30am. The medicines round was also interrupted on numerous occasions whilst the agency nurse dealt with other matters on the unit. This meant people were placed at an increased risk because their medicines were not administered in a timely manner, risk of staff mistakes through continued interruption and medicines not having the required minimum time between doses.

We also reviewed medicine competency checks completed with all staff who had responsibility for the management and administration of medicines. We were only provided with copies of three individual competency records completed during the previous 12 months. The prevalence of these issues was contrary to the service providers own medicines policy and the National Institute for Clinical Excellence (NICE) guidelines (March 2014) which states that 'care home providers must ensure that designated staff administer medicines only when they have had the necessary training and are assessed as competent to do so.' In addition care home providers should ensure that all care home staff have an 'annual review of their knowledge, skills and competencies relating to managing and administering medicines.'

During a tour of the home we identified a number of issues which gave cause for concern. On Mapledene we found a communal bathroom and toilet was being used inappropriately as an equipment store and was cluttered with wheelchairs and a goods trolley. The bathroom door was unlocked with no signage displayed to indicate the bathroom and toilet was not in use. This posed a potential trip and falls hazard for people. We also found a storage cupboard to be unsecured as the locking mechanism was missing. The cupboard was overfilled with moving and handling equipment and also contained medicinal creams, talcum powder and razor blades. Because the lock was broken on this door, this again meant people who used the service were placed at a risk of harm if they had gained access to any of the aforementioned items.

On Hollybank View unit we found a sluice room door to be unlocked despite the door being clearly labelled 'fire door keep looked'. The sluice room contained chemical products associated with cleaning and disinfecting and a sink with an active hot water tap. This placed people who used the service at a risk of harm through unintentional touching or drinking of the hazardous substances, a risk of scalding from the hot water tap and exposure to a risk of fire due to the fire door being left unlocked.

Despite the provider having a policy for infection control, we found aspects of the home were not visibly clean and were showing signs of wear and tear. This was of particular concern on Mapledene Unit where we found waste bins to be overflowing and food waste from breakfast remained on the floor throughout the first day of our inspection. Additionally, in the person's bedroom who was receiving nutrition through a PEG feed, their bedroom wall was partially contaminated with Enteral feed which had splashed back against the wall and not cleaned.

We raised these concerns with the operations manager during formal feedback and we were told Moston Grange was due to be refurbished as part of the providers rolling program of improvements across each of its locations. However, no date had been set for Moston Grange and this did not remedy the immediate infection control risks identified.

The systemic failures identified above demonstrated that safe care and treatment was not provided to people who used the service. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

We reviewed how the home sought to protect people who used the service from abuse. We found the provider had an appropriate safeguarding policy in place and a specific policy which encouraged staff to 'speak up' and raise concerns. However, whilst reviewing the care records of one person who used the service we found an incident report had been completed by a member of staff in February 2018 detailing an incident where an agency care worker was seen to remove a disposable apron from this person after meal time service in a manner that other staff did not deem appropriate and could cause injury. We saw the incident had been reported to the nurse in charge but we found no follow up action had been documented on the incident report form to determine this matter had been appropriately investigated. We raised this matter with the operations manager who confirmed to us that neither they nor any member of the management team at the home were aware of this incident because it had not been logged on the electronic recording system. This meant no investigation had taken place and no action had been taken in respect of the agency worker. We were therefore not assured that systems and process for safeguarding adults were sufficiently robust and that good safeguarding practice was embedded within the home.

This was a new breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of safeguarding service users from abuse and improper treatment.

We reviewed staffing levels at Moston Grange and found one nurse on each unit per shift would be supported by either three or four support workers; the variation on support workers was dependant on the nature of the service provided on a particular unit. Support workers reduced by one on each unit at night. Since our last inspection we found an increased use of agency staff. This had been compounded more recently due to the number of staff suspended from the home in relation to the provider's ongoing safeguarding investigation. We also found the home faced ongoing challenges retaining staff that had already been recruited. We discussed this with the operations manager and we were told this was a priority area for the provider and we were shown documentary evidence of analysis completed by the provider which explored the reasons for individuals leaving the organisation. The results of this analysis had helped to inform the provider's ongoing plans for the recruitment and retention of staff.

Comments from staff included: "At times the staffing has not been good, too much reliance on agency staff. But I feel we do have enough staff on duty now."; and, "I believe we have enough staff on duty on [unit], but I wouldn't like to say for the other units as I tend to just work on here." However, we found deployment of staff was not always effective across the home. For example, on one unit we found the activities coordinator was required to provide direction to the agency staff as the nurse on duty was busy tending to people's nursing needs. More widely, staff told us, and in particular nurses, that they did not feel supported at an operational level on their respective units because insufficient clinical support was provided. For example, one nurse described to us a typical morning shift and how very busy these were but they did not feel sufficient practical help was given by the clinical lead nurses or managers. Another registered nurse told us they did not believe the clinical lead nurses provided enough support day-to-day and they felt the role appeared to be more office based.

This anecdotal evidence from staff was supported through our own observations. As previously stated in this report, due to the lack of awareness and lack of support from the clinical nurse leads and managers with regards to the nurse on Mapledene, we saw extended periods of time taken to complete the medicines round and other associated nursing duties.

Comments from people who used the service included: "Staff are alright, show respect, come quickly but are rushed"; "I can't settle in my room. Nobody comes to see how safe you are"; and, "No trouble, I'm happy here".

We looked at the records of four newly recruited staff to check that recruitment procedures remained effective and safe. We found prospective new employee's completed application forms and the information provided included a full employment history and pre-employment checks had been carried out. These included Disclosure and Barring Scheme (DBS) checks, health clearance, proof of identity documents, including the right to work in the UK, and two references, including one from the previous employer. The DBS helps employers make safer recruitment decisions and aims to prevent unsuitable people from working with vulnerable groups. We also reviewed how the provider ensured the registered nurses who worked at the service maintained their registration. We saw the service kept a record of nurses' Nursing and Midwifery Council (NMC) PIN numbers and when their revalidation was due. Records showed all the registered nurses who worked at Moston Grange were registered and had a valid PIN.

Records and compliance certificates relating to the safety of the building and premises were examined and found to be up-to-date and in order. This included checks for gas and electrical safety, fire equipment, legionella and portable electrical appliances. Equipment used for moving and handling people had been serviced and maintained in line with regulations and manufacturers guidance.

The home had a business continuity plan which would be implemented in the event of an incident or untoward event that stopped the service. For example, fire, flood or electrical failure. Personal emergency evacuation plans (PEEPS) were also available should people require evacuation from the premises.

Requires Improvement

Is the service effective?

Our findings

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.
When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Due to nature of the service provided at Moston Grange, the vast majority of people were subject to a DOLS and the management team understood the need to apply for a DoLS authorisation in order to deprive someone of their liberty in order to keep them safe. A DoLS matrix was also in use to ensure key dates relating to all aspects of the DoLS process were tracked.

However, on Mapledene we found inappropriate practices which constituted a continued breach of regulation. We observed inherent restrictions imposed upon the movements of people who used the service. We found people were not supported to leave their own bedrooms at a time to suit themselves. Staff on duty told us access to communal areas had to be restricted due to a combination of availability of staff to meet people's needs and a lack of space in the communal lounge areas because the vast majority of people on Mapledene were not mobile and dependant on staff to support them. Staff told us they therefore had to 'stagger' when people could leave their room. This meant people on Mapledene were not afforded choice and were subjected to a disproportionate level of control. This was a fundamental infringement of their human rights.

This was therefore a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of safeguarding service users from abuse and improper treatment

In respect of care planning centred around mental health, we found that since our last inspection improvements had been made in this area. For example, a new document had been introduced called 'Dementia comprehensive risk/benefit and assessment tool.' This tool assessed a range of people's needs and an action plan was then devised. Improvements had also been made in documentation relating to consent. Where a person lacked capacity to make a particular decision, other relevant people had been consulted. For example, a person's appointed lasting power of attorney for health and welfare.

We looked at induction, training and professional development staff received to ensure they were fully supported and qualified to undertake their roles. The provider had a corporate induction programme for newly recruited staff and support workers who were new to the care industry were required to the complete the Care Certificate. The Care Certificate is a set of standards that social care and health workers adhere to in their daily working life. It is the new minimum standard that should be covered as part of induction training of all new care workers.

Staff training was a combination of classroom based learning with annual refresher training delivered via group sessions where staff would watch a DVD of the particular training topic. Staff were then required to complete a competency test to check their underpinning knowledge. Training topics included moving and handling, first aid, privacy and dignity, dementia and health and safety. Training for physical intervention and 'breakaway' techniques was delivered by an external training provider. Comments from staff included: "Training is always provided, I can't fault it."; "Not sure where I am up to with my training but I believe I am up to date with it all.", and "The permanent staff are well trained by the company but I can't say the same for agency staff we use."

We reviewed records relating to staff supervision and annual appraisal. Staff supervision provides an opportunity for line managers to meet with staff, feedback on their performance, identify any concerns, and offer support, assurances and learning opportunities to help them develop. We found registered nurses were required to participate in bi-monthly clinical supervision sessions and this process was supported by the provider's in-house policy for clinical supervision. General supervision was also completed with all grades of staff with a variety of standing items included at each session. Group supervision was also delivered to larger numbers of staff but we found this had not always been effective. For example, in February 2018 management had organised a group supervision session with the intention of discussing the importance of good record keeping. However, no members of staff attended. We learnt the reason for this was that permanent members of staff were unable to leave their respective units when there was a higher ratio of agency staff to permanent staff. This was because agency staff tended to not know people who used the service well enough.

On the first day of our inspection, we saw that a 'whole service' handover from night staff to day staff took place. However, following handover, we spoke with a qualified agency nurse who was on duty Woodside unit to ask them how effective they had found the handover to be. The agency nurse told us they had not been informed which unit they would be working on until after the handover had finished which meant they were not able to make their own notes on the written handover report that was provided for the unit. We were also told the written handover report contained only basic information and did not detail those people who used the service who might present with behaviours that challenge or those with special dietary requirements. The nurse further explained they simply asked staff on the unit in more general terms about the previous night but this was not in respect of individual people. This meant crucial clinical information concerning individual people was at risk of being missed.

Similarly to our findings from the last inspection, we received a mixed response from people who used the service with regards to the meal time experience. Comments included: "We should have more choice on meals, there is limited choice in food."; "I enjoy the food."; and, "The food is OK I suppose." We observed lunch time service on each of the four units and found people were offered a choice of two main options for their main meal which was served from a heated food trolley brought across from the main kitchen. People were able to eat either in the communal dining area or in their own room. Tables in communal dining areas were laid out with a table cloth, place mats and condiments. As previously mentioned in this report, one person on Mapledene was not appropriately supported to eat and drink during lunch time service. However, more widely, we found staff did offer an appropriate level of support to others who needed help.

During our meal time observations, we also found a disconnect between agency support workers and people who used the service. On each of the four units we found the agency staff tended to approach meal time service as a task and communication was poor, rather than seeking to support the permanent staff who sought to ensure the meal time experience was largely positive and one to be enjoyed.

In our last inspection report we detailed how improvements had been made which sought to ensure the environment at Moston Grange was suitable for people living with dementia. For example, on one unit we had previously noted interactive puzzles on the wall, containing locks and chains, which can be good for keeping a person with dementia engaged and interested and walls that were decorated with colourful transfers and framed pictures of old, local scenes. However, as previously mentioned in this report, due to the home now appearing worn in presentation, this detracted from these improvements. Furthermore, on Hollybank unit, we found people who used the service were unable to access the communal outside garden because the door was locked.

Staff told us this was because the surface was uneven and posed a risk to residents. We raised this during feedback and the operations manager told us an external contractor had provided a quote for the work required to make this area safe again and accessible to people. We asked to be provided with a timeframe for this work to be completed but at the time of this report, no update had been given.

We looked at how people who used the service were supported to maintain good health and to access health care services. We found people had access to relevant primary care services such as GP, district nurses and community mental health services and support was provided to ensure people were able to attend all relevant health appointments. However, more widely we found insufficient evidence to demonstrate how the service sought to promote good health and well-being. For example, we observed a number of people who used the service to be heavy chain smokers but the service did not promote any initiatives sought to help people reduce or stop smoking.

Requires Improvement

Is the service caring?

Our findings

We found there were widespread and significant shortfalls in the oversight and governance arrangements which meant people's immediate and ongoing needs were not consistently met to demonstrate a caring culture. Whilst we found staff had good intentions, they were not supported by the overall management or systems to ensure that people received safe, effective care when they needed it.

On each of the four units at Moston Grange, we completed a Short Observational Framework for Inspection (SOFI). This is formalised method of observing care to help us understand the experience of people who could not talk with us. We observed numerous examples of positive, caring interactions between staff and people who used the service. For example, on Deanvale unit a number of people who used the service were enjoying listening to music and were asking staff to dance with them. People were enjoying singing and staff provided positive encouragement by clapping and singing along. This was a spontaneous rather than an organised activity which people who used the service, and staff alike, appeared to enjoy. However, more widely across the home, we found opportunities for other forms of meaningful, positive engagement were often limited because care staff were primarily focused on the delivery of task based care.

We looked at how the views of people who used the service were sought and how engaged they were. We were told regular residents' meetings took place on each unit and feedback was provided by staff to members of the management team; we therefore asked to see minutes of meetings that had taken place since our last inspection. We were shown minutes of meetings held on Hollybank and Mapledene but no minutes were provided for Hollyview, Deanvale and Woodside.

In respect of meetings on Hollybank, we found these had taken place in July 2017, October 2017, January 2018 and February 2018. Meeting minutes indicated people who used the service had continually raised a variety of issues at each of these meetings concerning the environment on the units, recreational and social activities and the quality of food. In each case, the identified action was to raise these issues with the manager. However, the section of the meeting minutes which evidenced the issues had been discussed with the manager were blank.

In respect of Mapledene, we found a residents' meetings had taken place in February 2018. At this meeting concerns had been expressed about the poor laundry service and the fact underwear was not being returned and a lack of towels and bed sheets. The minutes also indicated people who used the service were not happy with the cleaning schedules at the home and people had suggested a cleaner was required to cover the whole seven day period and that carpets were in need of replacing. However, similarly to Hollybank, we found no evidence the minutes had been discussed with the manager or what action, if any, had been taken.

By failing to act on feedback from people who used the service, this was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in regard to Good governance.

We looked at the homes approach to equality and diversity and how the rights of people who shared a protected characteristic were promoted and respected. Protected characteristics are a set of nine characteristics that are protected by law to prevent discrimination. For example, discrimination on the basis of age, disability, race, religion or belief and sexuality. We found people who used the service at Moston Grange were from diverse backgrounds and the workforce was reflective of this. At corporate provider level, we saw how the organisation produced an annual report as required by the Public Sector Equality Duty, and we saw that mandatory equality and diversity training was delivered to staff. However, at a local level, whilst we found care and support documentation to be sufficiently detailed enough to capture people's individuality, we found no tangible examples of how the providers approach to equality and diversity at Moston Grange translated into quality outcomes and equality of opportunity for people who used the service.

We therefore recommend the service consults CQC's public website and seeks further guidance from the online toolkit entitled 'Equally outstanding: Equality and human rights - good practice resource.'

Requires Improvement

Is the service responsive?

Our findings

Since our last inspection of Moston Grange, we found improvements had been made to the overall format of care planning documentation and care records were now entitled 'My care and support plan' which sought to capture key information under a variety of headings. For example, my mental health and well-being; my mental health act status; my physical health needs; my personal care; my diet and nutrition; my relationships; my money; my social life; my relationships; and, my money. However, we found variation in the quality of information being recorded and the timeliness in which evaluations of care were completed.

On Woodside unit, we reviewed pre-admission documentation for one person who had recently been admitted into the home. We found the pre-admission assessment contained information detailing this person's baseline assessment but this had not been used to formulate a full care plan. This was despite this person experiencing a significant decline in their physical health, including a loss of mobility. Whilst we found appropriate and timely referrals had been made to NHS health care professionals, this person's newly emerging health issues had not prompted nursing staff to complete an evaluation of their care plan. This meant documentation within the existing care plan was out of date and not reflective of their current needs.

On Mapledene unit, a person had recently been discharged from hospital. During their hospital stay a clinical decision had been taken with regards to this person's resuscitation status and a 'do not attempt resuscitation' order was now held on this person's care records. However, despite this change, we again found no evaluation of the care plan had been completed since this person arrived back at Moston Grange. Also on Mapledene, the section of another person's care plan that related to their life story was blank and staff had simply written 'unable to remember.' This was despite this person having involved relatives who could have been consulted to provide this information.

On Hollybank unit, one person's care records contained a 'Positive Handling Plan.' Whilst aspects of this particular plan were useful, it had been handwritten and did not provide a clear overview of the keys issues and the record contained gaps. For example, this person's pre-admission assessment detailed a number of serious issues related to their hospital stay as a secure in-patient, including violence towards males. Information was also provided in the pre-admission assessment with regards potential triggers for behaviours that might challenge the service but the positive handling plan made no reference to this.

This demonstrated a failure to ensure accurate and up to date records were maintained. This was a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to good governance.

At our last inspection of Moston Grange, we were told how work was still 'in progress' with regards to the

home developing an activities programme that sought to ensure people who used the service were stimulated and engaged in meaningful activity. At this inspection, we found this work was still ongoing. During the inspection we spoke with an activities coordinator and they spoke with great passion about how they tried to support and motivate people who used the service to participate in a range of activities that were on offer. For example, they told us that on a daily basis they needed to gauge a person's individual mood and then seek to encourage them to participate in an activity that was most appropriate at that time. We were also shown some documentary evidence with regards to initiatives and activities that had took place during 2017. For example, we saw how this member of staff had written to two local professional football clubs to request a charitable donation of football scarves. Both footballs clubs responded positively to this and the scarves were then used to facilitate Armchair Football. A range of traditional communal activities also continued to be provided such as arts and crafts, a book club, afternoon tea and bingo.

The home also subscribed to the 'Daily Sparkle' newspaper which is a dedicated reminiscence newspaper and offers an ever-changing range of nostalgia topics and activities, targeted for older people and those living with dementia. We found The Daily Sparkle was used to good effect to facilitate discussions between staff and people who used the service.

On the second day of our inspection we observed the weekly 'breakfast club' which took place in the main communal dining room. Staff would bring people who used the service along from their respective unit and we saw that people enjoyed a cooked breakfast and that a selection of drinks was offered. For those people who were unable attend, a takeaway service was provided and a 'breakfast box' would be delivered. From the laughter and chatter between people who used the service and staff, this weekly event was clearly very much enjoyed by all involved.

More widely, further consideration needs to be given to ensure 'activities' were person-centred in nature in order to demonstrate a natural link between person-centred care planning and person-centred activities. In particular, ensuring a person's life history, personal preferences, likes and dislikes is captured in a meaningful way and translated into an activity or event that is personalised to them. During feedback we raised this with the operations manager and we were told that a dedicated occupational therapist had recently commenced work and was going to lead in this area of work.

We reviewed the homes approach to end of life care (EoLC) and we were told that in such circumstances, community EoLC professionals such Macmillan Specialist Nurses were usually involved, in addition to a person's own GP. Staff received EoLC and bereavement training as part of the mandatory training programme and this was delivered via a group DVD session.

People told us they knew how to raise a complaint and the provider had an appropriate policy in place and information was displayed around the home detailing how to raise a concern. comments from people who used the service included: "I would go to the office if I had a concern";
"Yes, I know how to do it [complain] I would speak to the staff first and if not happy I'd go to see the boss"; and, "I'd tell the nurse if I wasn't happy." A visiting relative told us they had previously raised a concern with the manager and that it had been resolved to their satisfaction.

Inadequate

Is the service well-led?

Our findings

In reaching our judgement about how well-led we considered Moston Grange Nursing Home to be, in addition to the failures identified during this inspection, we took into account the inspection history of the home. In particular, the fact the home has not been compliant with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 since 2016. Furthermore, following our inspection in July 2017, we served three warning notices for failures around safe care and treatment, safeguarding service users from abuse and improper treatment, and good governance.

We were clear in stating that significant improvements were expected and that compliance with these regulations was required within the given timescale. We were also clear that if the provider failed to achieve compliance with the relevant requirement within the given timescale, we would seek to take further action. Full information about the CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

At the time of this inspection, Moston Grange Nursing Home did not have a manager in post who was registered with CQC. A 'registered manager' is a person who has registered with CQC 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.

The operations manager told us they had been newly recruited in early 2018 following a management restructure carried out by the provider in late 2017. We were told the operations manager remit was originally to have oversight of several locations but since the emergence of safeguarding issues at Moston Grange and the resignation of the previous home manager, they were now based full time at the home and would be acting in a dual role which incorporated being interim manager of Moston Grange.

We reviewed what systems and processes had been implemented since our last inspection by means of audit to demonstrate the home was safe, people were receiving a good standard of care and quality monitoring was in place in terms of demonstrating good governance and compliance with regulations. We were told the audit and quality assurance was carried out by a member of staff who had specific responsibility for this area and that people who used the service were asked for their feedback on the quality of service through regular meetings which were held on each unit.

However, we reviewed audit and quality assurance records for the period from August 2017 to March 2018 and found no tangible improvements had been made. For the period from August 2017 to December 2017, audits had been completed for care plans, the environment, clinic room and medication, mattresses, hoists/slings, and complaints but we found insufficient information to demonstrate these audits had been analysed effectively to ascertain whether there were any similar themes or trends that required action. In respect of audits completed since January 2018, we found audits had only been completed for the environment and clinic room and medication but no audits had been completed in respect of all other areas. Again, where an audit had been completed, we found insufficient information to demonstrate these

audits had been analysed effectively to ascertain whether there were any similar themes or trends that required action.

In respect of the meetings held with people who used the service in order to obtain their feedback on the quality of service, as previously stated in the 'caring' domain of this report, we found there was a failure to act on this feedback.

This demonstrated a continued failure to complete regular audits of the service provided, which sought to assess, monitor and improve the quality and safety of the service and a failure to act on feedback. This was a continued breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to good governance.

Throughout the inspection, we asked members of the management team for a variety of documents to be made available. However, these were not always provided to us in a timely manner and inspectors were often required to ask several times before documentation was made available.

It is a legal requirement that providers display the rating they received at their last inspection, within the home and on their website if they have one. The rating of 'requires improvement' from our last inspection in July 2017 was not displayed in the home. Checks completed before the inspection demonstrated the rating was displayed on the provider's website. However, in respect of the failure to display a rating in the home, we are reviewing this matter outside the inspection framework.

During this inspection we found the effectiveness of the new management structure at Moston Grange had thus far not been demonstrated through real, tangible, positive outcomes for people who used the service. Furthermore, the areas of concern identified during this inspection and the resulting breaches of regulations, demonstrated that management oversight was inadequate and that systems and processes for audit, quality assurance and questioning of practice were ineffective.