Catholic Blind Institute

Christopher Grange Residential Care

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Christopher Grange is a residential care home providing personal care to 53 people aged 65 and over at the time of the inspection, including people living with dementia. The service can support up to 78 people and is comprised of four units.

People's experience of using this service and what we found
People told us that they were happy with the care and support provided by staff. However, the home did not always suitably manage risk to people.

Medicines were not always managed safely. Some environmental checks were either not in place or had not identified the concerns found at our inspection. People were exposed to a risk of harm.

The service was not always well managed. Practices across the different units were inconsistent. Assurance and auditing processes did not always adequately mitigate risk to the health and welfare of people living at the service.

The registered manager began to address our findings following the inspection, showing they were responsive to making the required improvements, and that the safety and quality of the service was a priority.

People's relatives spoke positively about the care and support their family member received. There were enough staff to meet people's care and support needs.

Staff told us they enjoyed their job and felt supported in their role.

The service appeared well maintained and clean and staff followed effective infection prevention and control measures.

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

Rating at last inspection
The last rating for this service was Good (published 12 June 2019).

Why we inspected
The inspection was prompted in part by notification of a specific incident, following which a person using the service died. This incident is subject to a criminal investigation and also involves other health care providers. As a result, this inspection did not examine the circumstances of the incident.

The information CQC received about the incident indicated concerns about the management of medicines.

This inspection examined those risks.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvements. Please see the Safe and Well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Christopher Grange Care Home on our website at www.cqc.org.uk.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information, we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Christopher Grange Residential Care

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors, an assistant inspector and a medicines inspector.

Service and service type
Christopher Grange a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced on the first day and announced on the second day.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback

from the local authority and professionals who work with the service. We used all of this information to plan our inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report .

During the inspection
We spoke with eight people who used the service about their experience of the care provided. We also spoke with the registered manager of the service and six members of care staff.

We reviewed a range of records. This included six people's care records and multiple medicines records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, were reviewed.

After the inspection
Due to the risks of coronavirus, we reviewed paperwork remotely where possible. We spoke with three members of care staff by telephone. We also spoke with five relatives to obtain feedback about the care and support received by their family member. We continued to seek clarification from the provider to validate evidence found. We spoke with the local authority to keep them informed of our inspection findings.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely
• Medicines were not always managed in a safe way.
• Medicines Administration Records (MAR) were not always completed fully so we could not be sure medicines had been given. Handwritten MAR charts were not accurate, which may increase the risk of medicine errors.
• For people who were prescribed PRN (as and when required) medicines, PRN protocols were not in place to provide staff with guidance on how and when to give this type of medicine.
• The quantity of medicines in the home did not always match what was on the MAR as medicines from the previous month were not always carried forward. This made it difficult for staff to audit whether medicines had been given.
• Time specific medicines were not always given at the correct time.
• Some medicines were stored in a refrigerator. The recording of the temperature of the refrigerator showed it to be outside of safe levels. However, the registered manager checked this and found that there had been an error with staff recording and not with the refrigerator temperature itself.
• For people who used topical medicines (medicines applied onto the skin), topical medication record charts (TMARs) did not provide staff with guidance on where and how often to apply these types of medicines.
• People's prescribed thickener (thickener is used for people with a swallowing disorder and helps minimise the risk of choking) was not managed safely. Staff did not always record the amount used when added to drinks so there was no evidence that this was being done correctly. However, on the second day of our inspection, we saw charts had been implemented for staff to record its use.

We found no evidence that people had been harmed, however, systems were either not in place or robust enough to ensure safe management of medicines. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
• Checks on window restrictors were not carried out and we found that some windows in people's bedrooms did not have restrictors in place. This meant that people were at risk of falling from height. However, on the second day of our inspection, window restrictors were in the process of being fitted.
• During our inspection we observed a cleaning trolley left unattended and an electrical cupboard left open for a prolonged period, meaning people were at risk of exposure to harmful chemicals. We also observed a fire door wedged open and a smoke seal on one fire door had been painted over. This meant people were at risk of harm from fire and smoke inhalation. We raised this with the registered manager, who confirmed this

would be addressed.
•. Other environmental checks, including fire safety checks, had been completed in line with the service's own policies. This helped to mitigate risks to people.
• People's personal emergency and evacuation plans (PEEPS) contained current information. This is important as PEEPS provide guidance for both staff and the emergency service on how to safely evacuate people from the building in an emergency.
• Appropriate risk assessments were in place for people, such as for mobility and risks of COVID-19. This meant staff had appropriate guidance on how to manage and mitigate any identified risks to people .
• People told us they felt safe. People told us, "I have never felt so safe in my life" and "As soon as I press my call bell staff are there."

Staffing and recruitment
• Suitable recruitment processes were in place to provide assurances that staff employed had the required skills and characteristics to work with vulnerable people.
• Whilst the service relied on agency staff at times, they were included in the service's COVID-19 testing programme to help minimise any risk of transmission of coronavirus.
• People confirmed and we saw there were enough numbers of staff on duty to meet people's care and support needs. Comments included, "The staff are very good", "Staff are so nice and go out their way for you" and "I feel safe. There's enough staff. Staff are very patient and caring and respectful of my dignity."

Preventing and controlling infection
• We carried out a visual inspection of areas of the home and found the home was clean, tidy and odour free. A relative told us, "The home is so clean and tidy all of the time."
• The service did not have any cases of COVID-19 at the time of the inspection. We were assured that the provider was preventing visitors from catching and spreading infections, meeting shielding and social distancing rules and admitting people safely to the service.
• We were assured that the provider was using personal protective equipment (PPE) effectively and safely and was accessing testing for people using the service and staff.

Learning lessons when things go wrong
• A system was in place to record any incidents or accidents. The recording and oversight of the information was effective at identifying any trends and help prevent any future risk and reoccurrence.

Systems and processes to safeguard people from the risk of abuse
• Staff spoken with told us how they were able to recognise and report on safeguarding matters.
• There was a policy on safeguarding in place which provided staff with up to date information.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care;
• The service was made up of four units each led by a unit manager. There was not always a consistent approach to governance processes to ensure oversight and leadership within the service.
• Systems and processes did not always operate effectively to prevent harm to people and had not identified the concerns found at our inspection.
• Audit processes had not highlighted that records were not always being properly maintained.
• Where people had been assessed as needing a specific diet, it was not evident that their nutritional and hydration intake had been monitored and recorded to prevent unnecessary dehydration, weight loss or weight gain. Some people's nutritional and fluid records were incomplete.
• For people assessed with skin integrity needs and who were on position charts, although it was evident that the person had been repositioned, it was not recorded appropriately.
• People's personal care such as bathing, and showering were often recorded on more than one document which recorded inconsistent information and was confusing for staff to follow.
• Audit processes had not identified our concerns in relation to the management of medicines, record keeping and absence of window restrictors.

We found no evidence that people had been harmed but, due to poor governance processes, people were put at risk of harm. The provider failed to assess, monitor and mitigate risks to people. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The registered provider responded to our concerns proactively and provided assurances that auditing and governance processes would be re-assessed.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• Minutes of resident meetings showed people's views were sought on various topics and their wishes acted upon. One person told us, "I was asked what my favourite food was, I told them, and it was put on the menu."
• People told us they knew who the manager was, "The manager is the salt of the earth, the cherry on top of

the cake" and "The manager is approachable, if I had an issue, I would go and speak to them."
• Comments from people's relatives included, "The difference in [Name] being at the service is unbelievable, they are so settled," "Staff are marvellous with [Name], it's just everything", "Staff couldn't be more helpful and [Name] loves it at the home" and "I couldn't have picked a better home for [Name]."
• Staff told us they felt listened to and were able to provide feedback. One staff member told us, "My [unit] manager is good and [the registered manager] is very approachable. They come on our unit every day."
• The registered manager instilled a culture of person-centred care which was both practiced and valued by staff. Regular services were held in the onsite chapel to remember people who had passed on. People had created a dignity tree and had created messages about what dignity meant to them.

Working in partnership with others;
• The service worked with others such as commissioners, safeguarding teams and health and other social care professionals, to ensure people received the care they needed.
• Written feedback from a health professional who visited the service regularly stated, "Staff are always helpful, and I am confident that my decisions are followed through by staff."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• The service notified CQC of notifiable events in line with their regulatory requirements. We were assured that the provider had acted on their duty of candour and shared information appropriately with us.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to the health and safety of people living at the service had not always been assessed appropriately and medicines were not always managed in a safe and proper way. 12 (1) (2) (a) and (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes did not always monitor and mitigate the risks relating to the health, safety and welfare of people living at the service. Accurate and complete records in relation to the care and support provided to people were not always maintained. 17 (1) (2) (a) (b) and (c)