Care Quality Commission

Kirby Grange Limited

Kirby Grange Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We made an unannounced inspection of the service on 18 November 2015.

At our previous inspection in July 2014 we identified two breaches of regulation. These concerned management of medicines and supporting staff through training, supervision and appraisal. The provider had made improvements to meet the relevant requirements, but at this inspection we identified that aspects of support for staff had not been sustained although the provider had identified this and begun to address it before our inspection.

Kirby Grange is a residential care home providing care for up to 31 older people. Accommodation is on two floors. The home has two large communal lounges, a dining area and an enclosed garden. At the time of our inspection 23 people were using the service.

It is a condition of registration that the service has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. The service last had a registered manager in July 2014. A person has been managing the service since then but they had not, at the time of this inspection, applied to be a registered manager. This left the service without a registered manager for 16 months. This was a breach of a condition of registration.

Although people using the service told us they felt safe we saw evidence to the contrary. A person's care plan did not have any risk assessments despite there being a clear need for them. Action to carry our risk assessments was taken after we brought the matter to the manager's attention. Aspects of the environment of the home presented risks of harm to people. Window restrictors were `home-made' and were ineffective. That was evidenced by the fact that shortly before our inspection a person had tried to leave the home through a window. An equipment storage area and an area of the home undergoing renovation were not secure and a utility room was unlocked. All of these matters were addressed after we brought them to the attention of the manager.

People's rooms had pressure sensors which were switched off during the day which meant a person could have had an undetected fall in their room. Call alarms in people's rooms were switched off during periods of electrical work which affected how they could summon help at those times.

Enough staff were deployed to meet people's needs. The provider operated effective recruitment procedures.

We found minor recording errors in the services controlled drugs register. During a medicines round a person was left alone with their medicines for 10 minutes.

People using the service and relatives felt staff were adequately trained. Staff training and supervision had

fallen behind but this had begun to be addressed by the provider before our inspection.

Staff communicated effectively with people most of the time but communications were hindered because a lot of people were hard of hearing. We have made a recommendation to the provider about this.

There were reasonable doubts about whether a person had mental capacity to make decision about their care. No assessment had been made under the Mental Capacity Act 2005 and no consideration had been made about whether a Deprivation of Liberty Safeguards authorisation was required. This was addressed after we brought the matter to the attention of the manager.

Not all staff we spoke with had a clear awareness of the relevance of the MCA to their role.

People using the service told us they enjoyed their meals. They had a choice of meals, but less choice about how meals were served.

No action was recorded in respect of a person who had lost 10% of their body weight in nine weeks until we brought the matter to the attention of the manager.

Staff were caring and compassionate but we saw two instances of staff being abrupt.

People or their representatives had not been given their private mail for over two weeks. Their mail was not securely kept. Information on a notice board about the service was out of date.

People were provided with communal activities and, to a lesser extent, one to one activities.

People knew how to raise concerns and they had opportunities to provide feedback about the service.

The provider (owner) promoted an open culture and made themself available to hear people's concerns. However, we found a note in the staff room to the effect that staff must not give the manager's or provider's telephone number to relatives.

The provider had procedures for monitoring and assessing the quality of the service. However, those procedures had not identified concerns we brought to the manager's attention.

We saw several instances of things which could be improved. Most were not serious but they all pointed to a lack of attention to detail which meant people's experience of the service was not as good as it could have been.

We found one breach of regulation. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Staff understood their responsibilities to protect people from harm.

Staff had access to only one hoist which was not enough to ensure that people were supported with transfers without undue delay.

A person's care plan had no risk assessments despite being at the service several weeks. Window restrictors were `home-made' and were ineffective. Both matters were addressed shortly after our inspection.

Enough suitably skilled staff were deployed.

There were recording errors in a controlled drugs register.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The requirements of the Mental Capacity Act 2005 were not always followed until, but this was addressed after we brought to the attention of the manager.

Staff training had fallen into arrears but this was being addressed.

People's nutritional needs were met, although no action was taken in relation to a person's significant unplanned weight loss until after we brought the matter to the attention of the manager.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff were mainly kind and caring but we saw two examples of staff being abrupt or indiscreet when supporting people.

People were not given their private mail.

An information board included out of date information.

People using `quiet' lounges had their privacy interrupted by television and a music centre played at a very high volume in an adjoining lounge.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's individual needs were not always met. Reviews of care plans did not always identify concerns or result in actions being taken.

The provider promoted openness and encouraged people to raise concerns. However, we found an instruction to staff that the provider's and manager's telephone numbers were not to be given to relatives.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The service had not had a registered manager for 16 months, and no progress had been made to submit an application to register a manager.

Several notifications that should have been made to CQC about head injuries people suffered were not made.

Quality assurance procedures had not identified matters we brought to the manager's attention.

CareQuality Commission

Kirby Grange Residential 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 on 18 November 2015 and was unannounced.

The inspection team consisted of an 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. Our expert had expertise in caring for older people.

Before our inspection we reviewed notifications we had received from the service about events they have a statutory requirement to report, for example deaths of people using the service and serious injuries. Before our inspection, the provider completed a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make.

We spoke with seven people who used the service and two relatives of one of those people. We spoke with the manager, an assistant manager, a senior care worker, two care workers and a cook. We also spoke with the activities coordinator. We carried out observations of the care that people received as they spent time in the communal dining room and lounges. We looked at five people's care plans and associated records. We looked at two staff recruitment files to check how the provider operated their recruitment procedures. We looked at records associated with the provider's procedures for monitoring and assessing the quality of the service.

We contacted the local authority who pay for the care of some of the people to check if they had concerns about the service.

Requires Improvement

Is the service safe?

Our findings

When we inspected the service on 18 July 2014 we found that the arrangements for safe management of medicines were not effective and records of medicines administration were unreliable. This had a moderate impact because not all people were given their medicines. This was a breach of Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 which from 1 April 2015 was replaced by Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3). We required the provider to take action to meet the requirements of the regulation. The provider submitted an action plan of steps they were going to take. We found at this inspection that actions were taken and that management of medicines was safe, though we found minor inaccuracies in the provider's controlled drugs register.

People using the service told us they felt safe at Kirby Grange. A person told us, "This is the best place I could ever have. I feel safe here." Comments from other people included, "I feel safe. The staff make you feel safe", and "It is safe, it is because of the way the staff are." A relative told us they felt their [person using service] was safe. They explained they felt that because, "They are happy here. They like the staff." They added that they had "never seen anything that made them feel uncomfortable."

Care workers we spoke with understood their responsibilities for protecting people from avoidable harm and abuse. They knew about the provider's safeguarding procedures and how to recognise and report signs of potential abuse. A care worker told us, "I'm confident that if I shared any concerns with my senior or manager that I'd be listened to."
However, we identified a potential risk to people's safety. We saw that windows in people's bedrooms, corridors and communal areas that had window restrictors which were below the standards recommended by the Health and Safety Executive (HSE). The restrictors were `home-made' and consisted only of a short link chain secured by two screws. The window restrictors would not prevent a person climbing or falling out of a window. This was a concern because we learnt from a relative that a person using the service had tried to climb out of a window in a ground floor communal lounge on 30 October 2015. When we looked at the window we saw that the chain was broken. We could not find an internal report of the incident. After we discussed this with the manager arrangements were made to fit window restrictors that met HSE recommendations.

A person's care plan we looked at had no risk assessments despite them having used the service for seven weeks. During the early evening of our inspection we had to intervene after that person made another person clearly uncomfortable by their presence and physical contact. During this time care workers were present but had it not been for our intervention they would not have acted to separate the two people. Had risk assessments been carried out and properly implemented there was more likelihood the person would have been protected from potentially harming themselves and others. After we discussed this with the manager arrangements were made to carry risk assessments and they were completed on 20 November 2015.

Other care plans we looked at, apart from one we discussed with the manager, included risk assessments of activities associated with people's care routines. The risk assessments included information about how to support people safely and protect the, from avoidable harm.

People told us that when they used call alarms staff responded promptly. A person told us, "Staff come when I ring the buzzer. They come when I need help. I've used it twice today and staff came both times." However, the person added, "The staff tell me I use the bell too much." An issue that came into the conversation with people was that of call bells whilst electrical work was carried out at Kirby Grange. One person told us they used a telephone in their bedroom on the day the electrical works were being carried out to call for staff. This person told us they felt this was safe, but we didn't know if other people had the use of telephones at times call alarms were switched off. During our inspection we heard call bells being used throughout the day of our visit and staff responded in a timely manner. This however raised a concern about how people in their rooms would have been able to summon help and receive it promptly if they needed it during the electrical work. No risk assessments were in place to cover that contingency.

When we looked at records of a person no longer at Kirby Grange we saw that they had seven falls in less than a fortnight of which at least three resulted in head injuries. No record was made of why the person was falling so often or whether paramedics were called. None of the falls that resulted in head injuries were notified to the Care Quality Commission (CQC) which they should have been. When we spoke about this with the manager they told us the injuries were not `serious enough' to report, but we explained that all head injuries are serious and that the first injury may have been a factor in the subsequent falls. The manager agreed that in future all head injuries and injuries resulting in fractures, cuts and bruises would be reported to CQC.

We saw staff safely supported people with their mobility when people moved to different areas in the home. People who walked without assistance did so safely because the home was free of clutter. People moved around the home with various walking aides or wheelchairs. We saw care workers safely support people with transfers. The service had two hoists but only one was being used because the other was `out of action'. This was a concern because several people using the service required a hoist when they were transferred from chairs or bed to wheelchair and vice versa. Staff had raised a concern about only one hoist being available but the management response was that if another hoist was needed was `we would immediately have to hire one.' A care worker told us that one working hoist was not enough because it meant people had to wait whilst the hoist was being used for another person.

During periods that we walked around the home we noted that a utility room off a corridor that was used by people using the service was unlocked. This meant there was a risk people who were unsupervised could enter the room and become disorientated. We saw a door to an area of the home that was being renovated had a `do not enter' sign, but no lock or bolt. This meant people could enter a potentially dangerous area. This was addressed after we brought to the attention of the manager.

Several bedrooms had pressure mats which, when switched on, alerted staff if people had falls in their rooms. However, pressure mats were switched off during the day even when people were in their rooms. When we discussed our observations with staff they told us people would not go to their rooms. However, staff overlooked that some people were in their rooms. This carried a risk that people could have a fall in their room during the day but staff would not be alerted because alarms were switched off.

People using the service and relatives we spoke with told us they felt enough staff were on duty. A relative told us, "From what I've seen the home is adequately staffed." Our observations were that people were supported with their needs and no person was kept waiting when they wanted support. Decisions about

staffing levels were made by the manager and senior care workers. We were told that decisions were based on the dependencies of the people using the service. On the day of our visit a manager, a senior carer and three care workers were on duty plus a cook and domestic staff. That was the usual staff presence during the day. At night a senior care worker and two care workers were on duty.

The provider had effective recruitment procedures. All the required pre-employment checks were carried out including Disclosure and Barring Service (DBS) checks. These checks help to keep those people who are known to pose a risk to people using CQC registered services out of the workforce.

We looked at the service's controlled drugs register and randomly selected four pages. In three we found inaccurate entries. We asked a senior care worker to check those entries to make sure we had not misread the information and they confirmed there were errors. Those errors had no impact on people using the service but were an example of lack of attention to detail.

We observed people being supported with their medicines during a medicines administration round. We saw that medicines were given to people to take and the medicines administrator stood by whilst the person took their medicines. The medicines administrator did not tell the person what the medicines were for. However, one person was given medicines to take and the medicines administrator walked away to continue the medicines round. They regularly looked to see if the person took their medicines. After approximately ten minutes, the medicines administrator returned to this service person and said "Are you going to take these for me?" and the person did so. We therefore saw mainly safe and a single instance of risky practice. There was a risk that the person may have taken or mislaid the medicines without being seen to have done so. This meant that in such that instance there could be no certainty a person had taken their medicines.

Requires Improvement

Is the service effective?

Our findings

At our inspection on 18 July 2014 we found that staff were not adequately supported through training and supervision to be able to meet the needs of people using the service. This was a breach of Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 which from 1 April 2015 was replaced by Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3). We required the provider to take action to meet the requirements of the regulation. The provider submitted an action plan of steps they were going to take. We found at this inspection that actions were taken to improve training and supervision for staff but these had not been sustained. The provider had identified this before our latest inspection and had taken action to reintroduce and maintain the improvements that were made.

People we spoke with told they felt staff were trained. A person using the service told us, "The staff know what they are doing." Another said, "The staff are really helpful." A relative told us, "From what I've seen the staff are well trained."

In their PIR the provider told us about improvements they wanted to make at the service. These included ensuring that all staff were trained. We were told the service had a training plan but this was not available to view because it was an electronic record and there were problems with accessing the computer on the day of our inspection. A care worker we spoke with about staff training told us, "We [Kirby Grange] are excellent on staff training." They described that staff had received dementia training from nurses specialising in dementia care and were being supported to complete a series of training workbooks covering a broad range of subjects relevant to adult social care in a care home setting.

Providers are required by regulation to induct, support and train their staff appropriately. In our guidance for providers on how to meet the regulations, we are explicit about our expectation that those who employ adult social care workers should be able to demonstrate that staff have, or are working towards, the skills set out in the Care Certificate, as the benchmark for staff induction. The Care Certificate was introduced in April 2015. The provider had begun work to introduce the Care Certificate, but at the time of our inspection they were unable to evidence this. A person reviewing staff training at Kirby Grange told us, "The Care Certificate has been introduced, but there is no orientation to it. We're not able to evidence it."

We were told that staff training had fallen behind. Not all staff had refresher training when they should have had. This was linked to staff not having had regular supervision meetings when training needs should have been identified. A manager from another service run by the same provider was at Kirby Grange had begun a review of staff training and supervision arrangements before our inspection. They had taken steps to ensure that every member of staff had a supervision meeting at which training needs were discussed and addressed.

The 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 take particular decisions, any decision made on their behalf must be in their best interests and as least restrictive as

possible. The Deprivation of Liberty Safeguards (DoLS) are a supplement to the MCA. DoLS exists to ensure that people who lack mental capacity are deprived of their liberty only if there is no other way to look after them. Decisions to deprive a person of their liberty can only be made by a `supervisory body' – usually a person appointed by a local authority. We checked whether the service was working within the principles of the MCA.

Care plans we looked at contained evidence that assessments of people's mental capacity were made. However, we learnt from relatives of a person using the service that the person came to Kirby Grange following a `best interests' decision because they lacked mental capacity to make that decisions for themselves. That person's care plan did not include an assessment of their mental capacity. That person had been involved in an incident in which they attempted to leave Kirby Grange which raised a question of whether DoLS applied to them, but no consideration of this was made. We discussed this with the manager and an assessment of that person's mental capacity was carried out on 20 November 2015.

Not all staff we spoke with demonstrated an awareness of the MCA and Deprivation of Liberty Safeguards (DoLS). One member of staff told us that the MCA "was about protecting people from abuse and safeguarding them" which was only partly correct. Other staff showed a better awareness and explained that people were presumed to have mental capacity to make decisions unless there was evidence to the contrary. The provider had a MCA policy which explained the MCA and DoLS but not all staff were aware of it. There were no arrangements in place to monitor whether staff had read and understood the policy. The manager from the provider's other service had identified a gap in staff awareness of the MCA and DoLS and had arranged for staff to attend training and complete training workbooks about the MCA and DoLS. A member of staff told us "[the manager from the other service] has kick-started the training."

When we spoke with staff about the MCA most told us that they sought people's consent before they provided care and support. People using the service we spoke to confirmed that to be the case. One told us, "Some staff explain what they are going to do, for example help me wash or put my creams on." Another person told us, "They (staff) explain what they are going to do. They really are very helpful."

During our inspection we observed that staff mostly communicated effectively with people using the service. Staff spoke clearly and slowly and positioned themselves at eye level with the person they spoke with. We saw records in one person's care plan that stated the person's hearing aid was broken, but there was no record of any action taken to have the hearing aid repaired. Another person showed signs of not hearing people who spoke to them. Both staff and people using the service had to constantly repeat what they were saying, at times raising their voices and even talking next to their ear. We raised this with staff who told us the person had received new hearing aids recently but they were unaware if they were being used or turned on. This potentially made the day difficult for the person because they could not join in conversation. We also observed and heard an activity where people listened to a recording of an old comedy show. The recording was at a very high volume which made it difficult to hear anything else that was happening and impossible for us to have conversations with people. We were told that people who wanted to listen to the programme would not be able to hear it at a reduced volume. It also had the effect that staff spoke with raised voices to people using the service and each other. We recommend that the provider seeks advice from a reputable source about supporting people in care homes with hearing difficulties.

People told us they enjoyed their meals at Kirby Grange. A person told us, "The food is okay. I have a choice of food. I'm looking forward to today's lunch, its beef pie." Another person told us, "The food is excellent." After lunchtime a person told us, "It [the meal] was lovely" and another person said "The food is good, it is not always homemade but it is still good."

We had mixed feedback from people about whether they had a choice of meals. Most people told us they had a choice but two people were clear they hadn't been asked. One person said, "They don't ask me what food I want." Another said, "They don't ask about food, they know what I like and don't like by what I leave on the plate."

We saw from looking at records that people had a choice of what they had at breakfast, lunch and evening meal each day. On the day of our inspection people had a choice of homemade beef pie, cheese pie or a jacket potato with cheese for lunch. People were able to have salad and vegetables with their lunchtime meal, though no one was asked which vegetables they would like.

Staff served all of one of the meal options first before serving anyone the other option. People who had jacket potatoes were served before those having the beef pie. This meant some people at tables had their food served for a while before the whole table had been served. People didn't want to start their meal until their whole table had been served which meant that by the time they started their food it was beginning to get cold. The arrangements for serving meals did not take account of some people's preferred etiquette at meal times.

Apart from one person who asked for their meal to be cut up, which was done immediately, no other person required assistance with their meal. People with dietary needs, for example people with diabetes and vegetarians, had their needs met. The cook was aware of people's needs, for example they ensured that people with diabetes were served tinned fruit without syrup.

Supper was served from 4.30pm. A trolley from the kitchen was brought into the dining room and lounge area. It had an array of food including sandwiches with a variety of fillings, sausage rolls, pork pie, crisps, apple pies and jam tarts. Soup was also available. From our observations we concluded that people did have a choice of meals.

We saw in a person's care plan that over a period of nine weeks they had lost 10% of their body weight. The nutrition section of the care plan stated that where a weight loss of between five and 10 % occurred a nutrition plan was required. There was no nutrition plan. The care plan had been reviewed twice but the only record made was `Care plan reviewed. No changes made.' When we spoke with the person they spoke only in positive terms about their care and meals they had and so did their relatives. The person looked healthy. However, the information in the care plan pointed to a lack of effective monitoring of the person's weight loss. The manager took action to involve the relevant health professionals in that person's care after we discussed the matter with them. Other people's care plans we looked at contained evidence that their health was monitored and that the service worked with health and social work professionals and arranged visits by them to attend to people's health needs.

Requires Improvement

Is the service caring?

Our findings

People using the service spoke in complimentary terms about the staff at Kirby Grange. A person told us, "The staff are kind. I feel I matter to them." They went on to explain that staff did things that mattered to them. They told us, "My bed sheets are changed often and after they do the laundry I get my own clothes back." Another person told us, "The staff are nice. It's a friendly atmosphere." A relative told us, "I feel well welcomed and treated [by staff]."

We saw staff act in a caring way throughout the day of our inspection. They referred to people by their preferred names and engaged in conversation. They took their time while supporting people, for example at meals times or when they helped people up from their chairs or assisted them to other parts of the home. Staff held people's hands; put their arms around service users and offered comfort and reassurance.

Before lunch was served we saw people sat at their dining table for 15 minutes before their meals were served. People were supported to cope with the wait by staff who engaged in conversation with people. We heard lots of laughter and people began singing "why are we waiting?" This made what could have been a tedious wait a period when people had fun. However, also at lunch time, we saw a lack of attention to detail that would have made a positive difference to people. A person who didn't like broccoli had it included with their vegetables. Some deserts were served with cream but staff did not ask people if they wanted cream. A person who asked for fruit was served with fruit with cream. They said, "I am not that keen on cream" but staff did not offer to provide fruit without cream. Later in the afternoon when people were served sandwiches a person sitting alone in a quiet lounge was handed a plate of sandwiches by a care worker who said "here you go mate" then left. The care worker did not ask the person whether they wanted sandwiches then or which sort. The person appeared to be startled when this happened. When we spoke with the care worker afterwards they told us the person always had sandwiches at that time but that did not excuse the abrupt manner in which they were given.

Comments from people about staff included "the staff are good, they know me well", "the staff are really good and "some are better than others". A person told us of two occasions when a particular member of staff can come into their bedroom in the morning "in a bad mood" but added that "they mellowed over the day." Another person told us, "One or two staff are a bit sharp, but most of them are alright." We saw rare instances of staff being abrupt or indiscreet. For example, in the early evening a member of staff asked in a loud voice that we heard from the other side of the room, whether people wanted to go to the toilet. That was indiscreet and did not respect people's privacy or dignity.

Staff were alert to people's needs. Call bells were answered in a timely manner and were not left ringing for more than 45 seconds. When a person asked to be taken to the toilet staff responded immediately.

People we spoke with did not appear to understand what their care plan was. We could not gauge from what they told us how they were involved in decisions about their care and support. However, a relative we spoke with told us they felt involved and well informed about their parent. They told us they had been involved in discussions about their parent's medicines and informed us of an incident they were involved in.

People were given information and explanations they needed. A person told us, "They (staff) always check what I want and ask if they can do what is needed." Another person told us, "I can understand most of them (the staff) perfectly."

We saw that information on a public notice board was out of date or inaccurate. A `service user's charter' that was on display referred to a registered manager who had left Kirby Grange several years ago. A typed notice stated that people's bedrooms were `restricted areas' which was contrary to what the provider's visitors policy stated about relatives being welcome in people's rooms. An information leaflet about a specialist charity was out of date as the organisation changed its name several years ago. Other posters included information about safeguarding, abuse, doctor's surgery information, `house rules' and a staff handbook. This notice board had a lot of useful information, but the layout was disorganised and untidy for information to be seen and read easily.

We noticed that mail for people was kept in a box in a staff room. We only noticed this after a member of staff removed a coat that was covering the box. The box contained 16 letters, four for one person. We could see that 11 letters were postmarked 4 November 2015. We saw from the envelopes that the letters were from a local authority and two were from the Inland Revenue. By not distributing the letters or passing them to people's representatives people were denied access to information that could have been important to them. People's privacy was at risk through their private mail being kept in a staff room.

Staff correctly referred to Kirby Grange as `the people's home'. However, we saw two areas that were visible to people that were untidy and not in keeping with the principle that it was their `home'. The garden patio which is visible from a lounge still had remnants of fireworks from bonfire night. A staff smoking area that was visible from another lounge was very untidy with a high pile of cigarette ends. This was not respectful of the people living at Kirby Grange and was another example of the lack of attention to detail.

People had use of three large communal areas. One lounge was used more than the other two which were `quiet areas'. We saw people using all three lounges. We couldn't help but notice that when people were enjoying a recording of an old comedy radio show in the main lounge, the recording was played at very high volume. It could be heard in one of the other lounges which gave people in that lounge no option but to listen to it. It also defeated the purpose of having quiet areas where people could relax and enjoy a degree of privacy.

Relatives were able to visit Kirby Grange without undue restrictions. Several people received family visitors. One told us they went out with their relatives and another told us they went out shopping twice a week. Another had their own telephone line in their bedroom that they used to keep in contact with family and friends. They told us they thoroughly enjoyed being able to do this and that it was important to them. A person using the service told us, "it's a community, we are all good friends."

Requires Improvement

Is the service responsive?

Our findings

People we spoke with did not appear to understand what their care plan was. We could not gauge from what they told us how they contributed to the assessment of their needs and planning of their care and support. However, we saw evidence in care plans we looked at that people were involved in the assessments of their needs and that care plans included information that they and their relatives gave to the provider.

People we spoke with told us they experienced care and support that met their needs. A person told us, "The carers do what they should." People's care plans included information about what was important to them and how they wanted to be cared for and supported. A relative told us, "They (staff) understand [person's] conditions and how to support them." Staff we spoke with told us they looked at people's care plans as they were a source of information about people which they supplemented with what they learned about people when they grew to know them. Staff knew which people were more able to do things for themselves and which people were more dependent on support.

We saw nine cards relatives had sent with complimentary comments about how well staff had cared for and supported people using the service. One said, `staff take good care of [person using service] and follow up any problems they may have immediately.'

Before our inspection we received information from a relative of a person who used the service before transferring to a nursing home. The relative was concerned that the person's needs had not been met. The provider investigated those concerns. Whilst not agreeing with everything the relative said the provider accepted that the person's needs were too complex for the service to meet.

People's care plans were regularly reviewed, usually monthly. We saw from one care plan we looked at that no record was made at a review that a person had an unplanned loss of 10% of their body weight over a period of nine weeks. Nor was any record made of action that needed to be taken in response to that weight loss. The manager told us action was taken, but details of any action taken were not recorded. Action was taken a few days after our inspection to involve the relevant health professionals in that person's care.

People we spoke with could not recall being involved in reviews of their care plan, though they recalled being asked for their views about whether they felt satisfied with the care they experienced.

A person using the service told us they participated in `debates'. They also told us they liked to do things alone, such as read a daily newspaper. We saw several people doing that. People were supported to participate in activities at Kirby Grange by a full time activities coordinator. Activities aimed at supporting people to interact with others included games such as bingo and quizzes. People participated in arts and crafts sessions. The activities coordinator had begun to keep records of people's participation in activities and they tried to find out why some people did not participate. They did this by talking with people on a one-to-one basis to find out about their interests and then devised activities for those people. People were provided with dolls and teddy bears which we saw they found comforting. The use of dolls and other tactile objects is something recommended in research about supporting people with dementia. The activities

coordinator read poetry to people and they spent time with individuals supporting them with activities based on their interests although such time was limited to short sessions. They told us that they judged people's moods and provided activities in response to what they saw rather than rigidly follow a programme of activities.

People we spoke with told us they spent their time the way they wanted. We saw people spending time in the two `quiet' lounges or walking to their bedrooms. People told us they watched television in their rooms or read books, magazines and newspapers. When we spoke with a person in their room we saw they had reading material and items they needed to maintain their hobbies.

On the day of our visit, the activity in the morning was listening to a recording of an old radio show which people told the activities coordinator they had enjoyed in the past. In the afternoon, old comedy programmes were played on a television in a communal lounge. When those ended, general daytime programmes were left on the television.

A person using the service told us, "it's a community, we are all good friends." All of these things protected people from social isolation, but people depended on relatives and friends for that. Staff told us that no outings were organised for staff to take people out.

A person told us they used to play golf on a regular basis before they came to Kirby Grange. They told us, "I used to play golf, I miss that. I can still play although I would need a buggy as I can't walk round." The activities coordinator told us they were about to order an indoor golf game for that person.

We learnt that an external activities provider who specialised in activities for people living with dementia visited Kirby Grange six times between December 2014 and October 2015. This was something that was promoted by a local authority. The external activities coordinator provided `reminiscence' sessions based on experiences people had of life and society in the 1950s. The service's activities coordinator intended to provide similar sessions and was discussing the purchase of equipment to use in reminiscence sessions.

People we spoke with told us they felt comfortable about expressing their views or raising a concern. A person told us, "I can say to staff when they have missed doing something. Sometimes, not very often, I have to remind them to help me with my creams." Another person told us they knew how they could make a compliant, but they added they had never had anything to complain about.

The provider's complaints procedure was displayed on an information board. However, the notice board was untidy and we had to search for the complaints policy rather than find them prominently displayed. Relatives told us they knew how to make a complaint. Complaints were investigated by the manager and the provider. Not all complainants were satisfied with the responses they received, but we saw that the provider had acted in response to criticisms complainants made about the service. However, the provider had not told a complainant where they could refer their complaint to if they were not happy with the response.

Requires Improvement

Is the service well-led?

Our findings

It is a condition of registration that the service has a registered manager. The service had not had a registered manager since July 2014. We were informed a manager who joined the service shortly after our last inspection in July 2014 would apply to be a registered manager but they had not, by the time of this latest inspection, applied. There were mitigating reasons outside of the provider's control that explained part of the delay. However, by the time of our inspection the delay was excessive. This is a breach of a condition of registration.

The provider has taken action to strengthen the management team by sending an experienced deputy manager from another service to Kirby Grange two days a week. We saw positive benefits of that action on the day of our inspection. For example, arrears in staff training and supervision had been addressed. Staff we spoke with appreciated that. In addition a permanent deputy manager post had been created and was being recruited to. That would strengthen the management team at Kirby Grange.

The provider (owner) regularly visited the service. They promoted openness and encouraged staff to raise any concerns they had and made themselves available to people using the service, relatives and staff. However, we chanced upon a hand-written note in the staff room which read `please make sure staff know to never give out [owner's] phone number.' That was contrary to the spirit the provider promoted.

People using the service knew who the provider and manager were. A relative of a person using the service told us, "The manager is approachable and makes themself available." A member of staff told us, "The manager has made a lot of positive changes. Kirby Grange is a much nicer place for people to be than it was 12 months ago."

A service is required to inform the Care Quality Commission (CQC) of certain incidents. These include injuries to people using the service and the failure of equipment, for example an elevator that people rely on, that exceeded a 24 hour period. When we looked at records of incidents that were reported internally using the provider's incident reporting procedures we identified six incidents between July and October 2015 where two people using the service suffered a head or facial injury or bruising to the body. None of those incidents were reported to CQC. That meant we could not take action in response to those incidents. One of those people went on to have six further falls in less than two weeks which may have been prevented had we received notifications and required the provider to take action to prevent or minimise the risk of further falls.

A person using the service told us of "several occasions" when the lift at Kirby Grange was out of service. They told us the lift "[was] never out of use for more than two days." During those periods people with upstairs accommodation who relied on the lift had to stay in their rooms. We looked at notifications we received from the service but none referred to the lift being out of use for more than 24 hours.

The provider had quality assurance procedures for assessing and monitoring the quality of the service. These included ways of receiving feedback from people using the service, relatives, health and social care

professionals who visited the service and staff.

The provider's quality assurance procedures consisted of a range of audits. These included audits of people's care plans and records, audits of the services procedures for management of medicines and checks of the safety and maintenance of the premises. Audits of people's care plans and records had fallen into arrears. At the time of our inspection those audits had not been carried out for six months. Audits that had been carried out had not identified shortcomings we brought to the attention of the manager, for example the quality of window restrictors, bathrooms not having privacy locks, a damaged wheelchair, a broken light fitting outside a bathroom and people having access to an area of the building undergoing renovation.

The provider's visits were also used to keep under review the quality of service and staff performance, conduct and behaviour.

The provider was registered for a regulated activity – treatment of disease disorder and injury – they did not provide. This was not an error on the provider's part but a case of over registration when the provider registered with CQC.

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 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 5 Registration Regulations 2009 (Schedule 1) Registered manager condition It is a condition of registration that the service has a registered manager. The service has not had a registered manager for 16 months. No application for a person to be registered manager has been received in that time.