People First Care Ltd

The Grange

Inspection report

Church Road
Rennington
Alnwick
Northumberland
NE66 3RR

Tel: 01665577344

Date of inspection visit:
10 February 2016

Date of publication:
06 May 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The Grange is registered to provide two services; a care home and a home care service. The services were last inspected July 2014 and all of the regulations we inspected at that time were met. This inspection took place on 10 February 2016. The inspection of the homecare service was announced and we gave the provider 48 hours' notice to ensure that a member of staff would be available at the office to facilitate our inspection and organise visits to people's homes. The inspection of the care home was unannounced.

We have written our report under the headings Homecare and Care Home to ensure that our specific findings for both services are clear. The Grange also provides day care but we did not inspect this as it was outside of the scope of our regulations.

Homecare service.

The Home care service supported 28 people who lived in their own homes in Northumberland. This equated to 400 hours of care a week.
There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The registered manager and senior care coordinator assisted us with our inspection.

We checked the management of medicines and found that there were no lists of medicines with the dosette box from which medicines were administered. Instructions about what should be administered were unclear.

Safeguarding procedures were in place and staff were knowledgeable about what to do if abuse was suspected.

Risk assessments had been carried out which documented action staff should take to minimise risks.

Staff were unhurried and calm while delivering care and care home staff were able to provide support in the event of sickness or unexpected absence.

There were no capacity assessments completed for people using the homecare service or best interests decisions recorded in relation to using specific pieces of equipment. A new consent to treatment policy had been developed and progress had been made towards improving practice in the care home, but this was inconsistent between the two services. We have made a recommendation about this.

Staff received regular supervision and appraisals in both services. Staff told us they felt well supported. Records of induction did not record competency assessments in aspects of care delivered by the homecare

service and this was passed to the manager who said they would address this.

Staff training had been provided but there were gaps in training records and staff had not completed training in the Mental Capacity Act 2005. One staff member had not completed any training for a year and this had not been addressed through the manager's performance management system.

People and relatives were complimentary about the care provided by staff. We saw that they spoke kindly and courteously with people in both services and a number of cards and letters commented upon the kindness and care shown by staff.

Audits of medicines management and care plans had not been carried out and. The manager advised that the audits had been delayed due to the increase in workload following the rapid expansion of the homecare service.

We judged that there was insufficient management time devoted to the homecare service, however a manager had been appointed in the care home to support the planned reorganisation of the management of both services.

Care home service.

The service was located in Rennington village close to the town of Alnwick and was registered for 26 people and there were 24 people using the service at the time of the inspection, some of whom were living with dementia. We were supported during the inspection by the registered manager and deputy manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The registered manager and senior care coordinator assisted us with our inspection.

We checked systems for the safe ordering, receipt and return or disposal of medicines. We found that medicines were not always stored safely as staff were routinely leaving the keys in the lock of the medicine cupboard.

The safety of the premises and equipment were routinely checked and emergency contingency plans were in place to ensure the continuity of the service during inclement weather for example. One safety certificate was unavailable at the time of the inspection.

Recruitment procedures included obtaining references and applicants were checked by the Vetting and Barring Service (DBS). The DBS checks the criminal record of applicants and whether they have been barred from caring for vulnerable adults. This helped to protect people using the service from abuse.

The home was clean and systems were in place for the control and prevention and spread of infection. Staff were knowledgeable about the procedures to follow.

A record of accidents and incidents was maintained which were analysed by the manager. Equipment was provided to reduce the risk of accidents for example falls sensor mats which alerted staff to the movement of people prone to falling.

There were adequate numbers of staff on duty during the inspection and relatives told us that staff had time

to care.

Staff records checked confirmed staff had received regular training and plans were in place to provide staff training in the Mental Capacity Act 2005 (MCA). A new consent to treatment policy had been developed and care records contained improved documentation to support staff to work within the principles of the MCA.

Nutritional needs were supported and people had access to professional advice and specialist diets where required.

Bedrooms we saw were individualised and homely. Some areas of the home were in need of redecoration and refurbishment and we saw that plans were in place to complete this. There was a lack of storage which had been identified by the provider and there were plans in place to provide additional storage outside the building. We observed an item of equipment being stored inappropriately. This was addressed immediately and plans were in progress to provide additional suitable storage. A planning application was in place to extend the building.

Staff were polite and courteous and responded with humour and sensitivity to people. They were quick to respond when people appeared worried or anxious. The privacy and dignity of people was maintained.

A registered manager was in post and was supported by a deputy manager. A new manager had been appointed as there were plans to strengthen the management of the service by appointing the registered manager into a senior operational management role within the organisation.

Staff and relatives told us they felt well supported by the manager and that morale was good in the home.

Systems were in place to seek the views of people relatives and other stakeholders including meetings and surveys.

We found two breaches of the health and Social care Act 2008 (Regulated Activities) Regulations 2014. These related to safe care and treatment and good governance.

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

Not all aspects of the service were safe.

Systems were not fully in place for the safe storage and administration of medicines.

Safety checks on the premises and equipment in the care home were carried out although not all records were available.

Risk assessments had been carried out in the homecare service to protect people from risks including during the moving and handling of people and environmental risks.

Safeguarding procedures were in place and staff were knowledgeable about what to do if abuse was suspected.

Is the service effective?

Requires Improvement

Not all aspects of the service were effective.

The care home service and the homecare service were inconsistent in their application of the principles of the Mental Capacity Act 2005 although work to improve this was in progress.

Some areas of the care home were in need of refurbishment and redecoration. Plans were in place to address this.

People's nutritional needs were met in both services.

Training was provided with the exception of mental Capacity Act training which was planned. Staff received regular supervision and appraisals. Spot checks had been introduced in the homecare service.

Is the service caring?

Good

The service was caring.

We saw that staff in the homecare service and the care home service spoke kindly with people and treated them with respect.

The privacy and dignity of people was maintained in both services.

A number of compliments had been received which praised the care and kindness staff had shown people.

Behavioural disturbance was supported sensitively and appropriate advice was sought.

Is the service responsive?

Good

The service was responsive.

Individualised and person centred care plans were in place.

The homecare service had begun monitoring missed calls and were in the process of introducing an electronic call monitoring system to support this.

A variety of activities were provided in the care home including visits from a range of therapists and trips outside the home.

People in both services had access to appropriate health care professionals when required. Emergency health care plans were in place where appropriate.

Is the service well-led?

Requires Improvement

Not all aspects of the service were well led.

It was considered that insufficient time was allowed for the dedicated leadership and management of the homecare service.

There was no procedure in place to guide staff what actions they should take if there was a missed call in the homecare service.

Regular meetings were arranged for people and relatives to share their views in the care home and surveys were sent to stakeholders to monitor the quality of the service.

Staff and relatives told us they felt well supported by the manager and provider and said they were approachable and accessible.

The Grange

Detailed findings

Background to this inspection

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

This inspection took place on 10 February 2016. The Grange is registered to provide two services; a care home and a homecare service. We inspected both services but only gave short notice to the homecare service. We gave the provider 48 hours' notice to ensure that a member of staff would be available at the office to facilitate our inspection and organise visits to people's homes. The inspection of the care home was unannounced.

The inspection was carried out by two inspectors. We spoke with four people who lived in the care home, and two relatives. We spoke with three people who received the homecare service and a relative.

We looked at the care plans of four people living in the care home and the care records of three people using the homecare service. We looked at the recruitment files of four staff and records relating to the management of the service including staff meeting minutes and audits. We looked at records relating to the safety of the environment and equipment.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk to us.

We spoke with the registered manager, unit manager, deputy manager and a senior coordinator. We spoke with six care staff, the activities coordinator, one cook, one domestic, and the nominated individual. A nominated individual has responsibility for supervising the way that the regulated activity is managed.

We consulted the local authority contracts and safeguarding teams and a member of the challenging behaviour team who all told us there had been no concerns received by them about the service and that there were no current safeguarding issues.

.

We displayed posters to inform people that we were inspecting the service and invited them to share their views with us.

Requires Improvement

Is the service safe?

Our findings

Homecare Service

We checked the management of medicines and people and relatives did not raise any concerns and told us that medicines were administered as prescribed.

Staff administered medicines from pharmacy filled dosette boxes. A dosette box helpe people to organise their medicines (tablets). They have separate compartments for days of the week and / or times of day such as morning, afternoon and evening. We checked two medicines administration records (MARs). Staff had recorded on the MARs "Dosette box," there was no up to date list of medicines which meant it was not clear what medicines had been administered from the dosette box. We checked one person's boxed medicines and noted that the label stated that one tablet should be administered. However, staff were recording that only half a tablet was being administered. It was not clear from records viewed whether half or one tablet should be administered.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed out findings with the manager and following our inspection, the manager wrote to us and stated that they were holding a staff meeting to discuss the recording of medicines and MARs.

There were safeguarding procedures in place and staff were knowledgeable about what action they would take if abuse was suspected. They said they had not witnessed anything which concerned them. There were no organisational safeguarding concerns and this was confirmed by the local authority safeguarding adults team.

Risk assessments were in place which documented actions for staff to take to minimise risks to people and staff such as moving and handling and environmental risks in the persons own home.

There were 10 staff employed to care and support 28 people who lived in their own homes. The manager told us that sometimes the Care Home staff assisted the Homecare service if staff phoned up sick at short notice.

People told us that staff always turned up and stayed for the correct amount of time. We followed staff on their visits to people's homes and observed that they carried out their duties in a calm and unhurried manner.

Staff told us and records confirmed that appropriate recruitment checks were carried out prior to starting work at the service to help ensure that staff were suitable to work with vulnerable people. These included Disclosure and Barring service checks (DBS) and obtaining references. The DBS checks the criminal records of applicants and checks whether they are barred from caring for vulnerable adults.

Contingency plans were in place to ensure the continuity of the service during any emergencies such as severe weather conditions. Staff had access to a four wheel drive vehicle in case of poor driving conditions. In addition, the provider offered to supply winter tyres for staff cars to help ensure the safety of staff.

Care Home

We checked the management of medicines. There were procedures in place for the ordering receipt and disposal or return of medicines. The home had been audited by the NHS medicines optimisation pharmacy team who had advised that two signatures were required for the administration of controlled drugs (medicines liable to misuse), and that these medicines should be audited weekly which the service had commenced. We found that medicines were not stored safely. Although only senior staff had access to the locked treatment room, they were routinely leaving keys in an internal medicine cupboard door. This meant that medicines including controlled drugs were not stored securely.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked medicine administration records (MAR's) and found there were no gaps in the recording of medicines given on the charts we viewed. We checked the stock levels of controlled drugs and found the correct quantities were in stock. Where medicines were administered via a patch placed on the skin, an appropriate record was maintained to ensure staff knew where they should be placed. Medicines refresher training was carried out annually for all staff.

A five year electrical safety test had been carried out but the certificate was not available on the day of the inspection. The electrician was on holiday so the provider was unable to obtain a copy at that time. They assured us that testing had been carried out, and provided us with a copy of the report after the inspection.

We checked the recruitment records of staff. We found that references were sought from previous employers and checks were carried out by the Disclosure and Barring Service (DBS). Risk assessments were completed to enable staff to shadow more experienced staff while awaiting the results of these checks but they were not left unsupervised with people using the service until these had been fully completed. Where issues had been identified during the recruitment process, we found that the registered manager had carried out an appropriate risk assessment in relation to their decision to employ staff, which was clearly documented.

The safety of equipment such as hoists and wheelchairs used to move people was checked and we saw that these had recently been serviced. A legionella risk assessment had been completed and appropriate procedures were in place to prevent the development of legionella bacteria, such as checking water temperatures and decontaminating showerheads on a regular basis. This showed the provider sought to maintain the health and safety of people, staff and visitors.

There were safeguarding procedures in place and staff told us, and records confirmed that training in safeguarding vulnerable adults had been completed. A staff member told us, "I would recognise signs of abuse and I would go straight to my manager." One person told us, "I feel very safe here. I couldn't feel safer." A relative told us, "My relative is safe and sound, and very well looked after."

We saw evidence of fire safety training and regular fire drills. Fire equipment was checked on a regular basis. We saw that a hoist had been left in the corridor in front of a fire exit. We discussed this with the provider and the manager who confirmed that it should not be left there and said they would ensure it was stored appropriately. Lack of suitable storage was identified during the inspection, and the provider and manager

had already identified this issue. They planned to provide additional storage outside the building, and we saw that quotes had been sought for the purchase of insulated storage sheds. In the meantime they confirmed that they would monitor the storage of equipment to ensure safety was not compromised.

There were adequate numbers of staff on duty on the day of the inspection. The registered manager explained that there was a degree of flexibility within the staff rota to allow for increases in staffing in response to a change in need. For example, additional staff were provided at night if someone was restless or at increased risk at night. Staff also told us that if they needed extra help that this was provided, including for planned recreational activities. A relative told us, "Staff are always available if you need to ask them something. They seem very organised and if you need anything it is provided quickly." Another relative said, "The staff are always having a word as they go by; they all have time to have a word."

Individual risk assessments were carried out in relation to the safety of people including their risk associated with falls, moving and handling needs, behavioural disturbance, and risks associated with the accidental ingestion of substances such as denture cleaning tablets. This meant that staff were able to put precautions in place to minimise risks to people.

The service was clean and there were no malodours. We spoke with members of domestic and laundry staff who were knowledgeable about the procedures to follow to prevent and control the spread of infection. Another staff member told us, "We have a champion who goes to infection control meetings at the hospital and makes sure we are up to date. Staff are good here for wearing gloves and aprons and we know what to do if there was an outbreak [of infection]."

Contingency plans were in place to ensure the continuity of the service. For example, a back-up electricity generator had been provided during recent high winds in case of a loss of power to the building.

The care home was located in an old building with a good deal of character and people and relatives told us they were very happy with the premises and facilities. One person told us, "I'm very happy with my room. They've even put a new heater in for me, isn't that kind?" A relative told us, "It was the homeliness of the service that attracted us in the first place." A number of areas in the home were in need of redecoration and refurbishment. An audit of the premises had been carried out and we saw a list of maintenance and repair tasks including the redecoration of some rooms. Repairs were also needed in some bathroom areas where the toilet roll holders and a hand rail had come off the wall. The registered manager confirmed that this would be addressed. The provider shared with us their plans to extend and improve the premises which were in progress and a planning application had been submitted. The provider confirmed that where possible, attention would be paid to enhancing the environment in line with best practice guidance relating to supporting people with dementia during the refurbishment and redecoration process.

Requires Improvement

Is the service effective?

Our findings

Homecare Service

People told us that they considered staff were knowledgeable and knew what they were doing.

Staff informed us that they considered that there was sufficient training for them to look after people. One staff member informed us that they had not completed any training since they had started a year ago. We checked this with the registered manager who told us that they had been registered to complete online training but had not yet completed this.

Staff told us that they received a period of induction both at the Care Home and within the community. The manager explained that the time spent in the Care Home enabled them to observe how new staff interacted with people and also enabled them to monitor their progress. Staff then shadowed an experience member of staff in the community. We read induction training records and noted that there was nowhere to confirm that new staff had been assessed as being competent in areas such as moving and handling, personal care and nutritional support. Following our inspection, the manager wrote to us and stated, "As discussed I have introduced a competencies [check] into the induction process."

The manager provided us with a training matrix. We noted that there were some gaps in staff training. The manager told us that staff had previously completed this training and the training matrix documented training which was due and needed updating. We checked two staff training records and noted that they had completed training in safe working practices such as moving and handling and medicines management. We noticed that staff had not completed MCA training. The manager told us that a manager of the Care Home service was going to deliver this training.

There was a supervision and appraisal system in place. Staff told us that they felt supported. One staff member said, "[Name of senior care coordinator] is very supportive, he's always there."

Spot checks had recently been introduced. The senior care coordinator carried out unannounced checks of staff whilst they were on their calls. This was to check whether staff were following the correct policies and procedures and observe their interactions with people who used the service. Infection control and medicines management were checked amongst other areas.

We checked three people's care files and noted that there was no evidence that people's capacity had been assessed to ascertain whether their plan of care amounted to a deprivation of liberty. In addition, there was no evidence that mental capacity assessments had been carried out for specific decisions such as the use of bedrails. A consent to treatment policy had been introduced in February 2016 which was in the process of being implemented. Training in the Mental Capacity Act 2005 was planned and we were shown the content of the training which was comprehensive and contained true life examples to support staff understanding of the types of issue that they might encounter. We noted that the care home service had made further progress in this area yet the application of the new policy was not consistent throughout both services.

We recommend that the Homecare Service operates in line with the requirements of the Mental Capacity Act 2005.

Following our inspection, the manager sent us a copy of the new documentation which they had developed to evidence how they were following the principles of the MCA.

We checked how people's nutritional needs were met. We visited one person at lunch time. They told us that staff prepared and cooked their meals. We saw that the meal was nicely presented and staff had made sure the person had a hot drink and a cold drink for later in the day.

We read people's care files and noted that they had access to both GP and the district nursing services.

Care Home

Relatives told us that they thought staff were knowledgeable and appropriately skilled to do their jobs. One relative told us, "The staff are excellent, they know how to cope with all the different problems people are having." Staff told us and records confirmed that they received regular training. The records we sampled showed staff had completed training in moving and handling, emergency first aid, end of life care, fire safety, equality and diversity, sensory deprivation, infection control, safeguarding vulnerable adults and medicines competency in the 12 months prior to the inspection. Staff were enrolled with the NHS learning and development online (computer based) training scheme and we saw that they had been written to by the manager, confirming their passwords to access the training and expected dates of completion.

Staff records sampled showed that staff had received supervision from their manager although there were some gaps in supervision records which we discussed with the registered manager. Staff told us they felt well supported by the manager and deputy. An annual appraisal had been completed which meant that the performance and development needs of staff was formally reviewed by the manager once a year.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act 2005 (MCA). 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 take 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). Capacity assessments had been carried out. The manager had submitted DoLS applications to the local authority for approval and was awaiting the outcome of these. Some had been authorised.

A consent to treatment policy had been introduced in February 2016 and training in the Mental Capacity Act 2005 was planned which included real life examples and scenarios to aid staff understanding of the subject matter. Consent to care and treatment forms had been added to care records. We saw that these were signed by the person where possible, for example, we saw a signed personal assistance care plan. Where people lacked capacity, family members were consulted. A risk assessment was seen in the care records of one person, which addressed the risk of the impact of a DoLS authorisation, in that their lifestyle choices could be restricted if this was applied incorrectly.

We observed a mealtime in the small dining area and saw that people received meals in line with their dietary needs including pureed meals. A relative told us, "The food is very good. My relative had trouble swallowing and needed medical input which was followed appropriately" and "They [people] are always being offered cups of tea and drinks, they get plenty." People told us they enjoyed the food, one person said, "Oh the food here is lovely, I always enjoy it."

Tables were fully set and staff explained what meal they were serving. Vegetables were served separately so people had a choice of side dish. One choice of drink was provided with the meal which was blackcurrant juice. There were ten people eating in the dining area which had seating for six. More people than usual were in the room because they had their hair done there earlier and then decided to stay. Some people therefore chose to eat their meal in a chair with a table, which meant that staff were quite busy as a number of people required prompting and support due to their dementia related condition. We shared our observation with the registered manager that this had the potential to impact upon the quality of the mealtime experience for a small number of people who had to wait for assistance, and staff confirmed that this was not normally the case. People at the table enjoyed the social aspect of the meal and chatted with each other and staff present.

We checked the kitchen which was clean and tidy. We spoke with the cook who was knowledgeable about the dietary needs and preferences of people and lists of special diets including fortified meals, diabetic diets, or low potassium foods were available. Picture menus were available to help people to choose meals if required. Various events had been celebrated and the cook had made a Burns' supper and told us they always provided people with a homemade cake on their birthday. Weights of people were recorded monthly, and checked weekly where people were losing weight to enable closer monitoring. The Malnutrition Universal Screening Tool (MUST) was in use. This tool helps to identify people at risk of malnutrition. We saw that people received appropriate support where concerns with their nutrition had been identified such as referral to the speech and language therapist to assess swallowing.

Care records showed that people had access to health care when they needed it. One person told us, "I feel very well looked after, with me being ill, it has been really wonderful." A relative told us, "Whenever [name of relative] has a problem, staff are always on the ball and seek the right advice. They tell us what is going on and keep us informed of everything." Care records confirmed that people had regular access to GP's and nursing services where required.

Good

Is the service caring?

Our findings

Homecare Service

People and relatives were complimentary about the caring attributes of staff. One relative said, "They are very thoughtful." We read a completed questionnaire which stated, "Very happy with dad's care." People were involved in writing their care plans and these contained information about people's likes and dislikes to help staff provide more person centred care.

We saw positive interactions between people and staff. Staff sat and had a chat with one person and talked about the house which he had built. One of the care workers said, "This is our social time, so we can bond, it's important." When the care workers were leaving they said to the person and their relative, "Right our family, we are going to love you and leave you." They took time to ensure another person was wearing their favourite Chanel perfume.

People's privacy and dignity were promoted. We visited one person who required assistance with personal care. The staff member explained to us that they were shutting the bedroom door to protect the person's privacy.

Care Home

Staff spoke kindly and courteously to people throughout the inspection and one person told us, "I like it here, the people are nice. They are kind and come and see if you're alright." A relative told us, I think the staff are excellent, they are very helpful. They are always pleasant and cheery." A new staff member told us, "The staff here are very caring. I can't tolerate poor care but I have been very impressed with the staff they are all lovely."

We observed the interactions of staff with people using the service. We saw staff respond to people with warmth, humour and skill. We saw a staff member sit beside a person on a chair while joining in an activity and jokingly said to the person, "I'm going to fall on your knee!" The person smiled and said "That's alright, and pulled the staff member towards them, and touched foreheads with them affectionately. One person smiled as a staff member they recognised entered the room. They beckoned them over and held their hand and hugged them.

We observed an activity and we saw that people were appropriately encouraged and supported, and achievements celebrated. People enjoyed participating and then joined in a spontaneous song.

Staff were heard complimenting people. One staff member said, "Oh what a lovely colour your scarf is, it's green like the shoots outside because it's nearly spring." This also helped to subtly orientate the person to the season and prompted a discussion about this. We saw another person become anxious about paying for their meal and they were reassured by a member of staff who recognised that they were becoming worried.

Privacy and dignity of people was maintained. We saw that staff spoke with people discreetly about personal matters and knocked and waited before entering people's rooms. Records of people were stored correctly to maintain confidentiality.

A relative told us that they were impressed by the way staff supported their family member who experienced behavioural disturbance and distress. We spoke with a member of the challenging behaviour team who had worked with the home to support them to care for people experiencing prolonged behavioural disturbance or distress. They told us, "The staff at The Grange are very proactive. They work closely with us and are able to transfer their knowledge to a similar situation with another person. They keep behaviour charts and records that we ask them to. They support some quite complex people and proactively manage risks, for example by providing additional staff at a particular time of the day if necessary."

We saw a number of cards and written compliments to the service that had been received in the 12 months before the inspection. Comments included, "We feel so lucky that we found a home for our relative where the staff were all so caring, sensitive and always treated her as an individual, in a dignified manner." Another said, "Thank you for making [name of relative] time at The Grange so comfortable and cared for." A number of other cards of appreciation for the "kindness and care" shown were also seen.

Good

Is the service responsive?

Our findings

Homecare Service

People who used the homecare service told us that they were happy with the service provided. They informed us that staff always turned up and stayed for the correct length of time. One relative said, "[Name of care coordinator] spent all of Sunday afternoon helping me move furniture from the dining room into the study, so he now has his bedroom there which is much better. They go above and beyond." People were involved in devising care plans which supported staff to provide care that was personalised and tailored to the needs and preferences of people using the service.

People told us they received care from the same care worker or group of care workers.

The senior care coordinator stated that they had just started to monitor missed calls. He stated that there had been two in the last three months. The provider informed us that they were going to introduce electronic call monitoring [ECM]. ECM is the process of recording the start time, the end time and duration of home visits for people who are receiving home care. Staff 'clock in' and 'clock out' by telephoning a free number when they arrive and leave each home visit. ECM helps to flag up any missed or late calls.

People's care plans showed advice was obtained from the GP or district nursing service if there were any concerns about people's health. We saw that people's care plans were detailed and gave information about their needs, likes and dislikes.

There was a copy of the complaints procedure in the care file in people's homes. No one with whom we spoke said they had any complaints or concerns. There had been four complaints received in the last 12 months. These had been dealt with in line with the provider's complaints policy. Records were available to evidence what action had been taken in response to the concerns raised.

Care Home

People told us they were happy with the care they received. One person said, "I am well looked after, spoiled rotten." A relative told us they were pleased with the way that the service adapted to the changing needs of their family member and said, "I've been very happy with [name of relative] care. Things have changed a lot since they came in and they have always coped with the changes and made sensible adjustments."

We checked care records and found that they contained person centred care plans. This meant that people's personality, behaviour, likes, dislikes and previous experiences were taken into account when planning care. A personality profile including people's life story, needs and preferences was completed. This helped staff to care for people in the way that they preferred.

A one page profile was in place which outlined people's needs. Information was recorded about people's physical and emotional needs, and we read a "Life at the moment" profile for one person which said, "I feel

settled and happy. I get on really well with everyone. I know the routine of the home." This meant that the service was seeking the views of people about their experience of living in the service.

Care documentation influenced by the University of Bradford was in use to support the development of person centred dementia care plans. The University of Bradford is home to one of the leading dementia services development centres in the UK. Care plans were sensitively written using appropriate language, for example when describing the behavioural issues of one person.

End of life wishes were recorded and Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms, where used, had been reviewed and updated. Emergency Health Care Plans (EHCP) were in place where appropriate. An EHCP contains information to help communication in an emergency for the individual, to ensure they have access to the right treatment and specialist support.

An activities co-ordinator was in post and we observed activities taking place on the day of the inspection. We saw that activities were recorded in people's care records and that a variety of activities were planned and advertised. The activities co-ordinator had arranged for the service to provide a shop for people, which was open for a period of time during the inspection. This enabled people to purchase confectionary or toiletries and the profits were used to buy more items and to go towards fundraising for activities. There was a good deal of activity around and interest in the shop.

External activity providers also visited the home, including a creative artist, music therapist and a hand and knee therapist. A personal trainer visited once a week to carry out chair exercises in the lounge. An entertainer visited most months. People were able to take part in an art for relaxation course and were awarded a certificate once completed. Activities were planned in advance and staff had a guide about the activities to run in the absence of the activities coordinator. A car was available for use by the service and a staff member told us, "We go on lots of days out; we have the car and go to the places such as the garden centre. People enjoy the days out."

A complaints procedure was in place and available to people. One complaint had been received by the service, and we saw that the concern raised had been beyond the control of the service but they had addressed it formally and documented their reply.

Requires Improvement

Is the service well-led?

Our findings

Homecare Service

There was a registered manager in place who had been in post since the start of the homecare service in 2009. She had completed her Registered Manager's Award. The senior care coordinator was working towards a level 5 vocational qualification in leadership and management.

We checked how the provider monitored the quality and safety of the service. We asked whether any audits had been carried out. The manager and senior care coordinator told us that care plan and medicines audits had not been carried out yet. She said that the rapid growth of the Homecare service had impacted upon the auditing of the service since the focus had been on the provision of care. She said that they were training up two more staff to be coordinators to support the senior care coordinator in the monitoring of the service.

The senior care coordinator told us that reviews of people's care were carried out. We did not see care reviews in two of the files we viewed and one person had only recently started using the service. When we were back at the office, the senior care coordinator showed us an example of a care review which had been undertaken. He had difficulty however, in finding further reviews for us to check. An effective system to review people's care was not fully in place.

We identified gaps in staff training and found that one staff member had not completed training for over a year. While this had been noted, it had not been addressed through the manager's performance monitoring system.

There were policies and procedures in place for most activities to provide staff guidance. However, there was no procedure in place to guide staff what actions they should take if there was a missed call.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

Following our inspection, the manager sent us a copy of their missed calls procedure and flow chart which they had developed. She also told us that they had started auditing the care plans and medicines records.

Surveys were carried out to gather the views of people and their relatives, however these were undated. The senior care coordinator stated that these had been carried out recently. Feedback was very positive. One respondent had written, "I couldn't have coped without them." The manager saw staff during spot checks and staff meetings which gave them an opportunity to share their views about the service.

Care Home

A registered manager was in post but a new manager had been recruited with the aim of replacing the registered manager. It was planned that the registered manager would become an operational manager

with responsibility across the organisation. The registered manager was aware of the need for them to formally de register with CQC and for the new manager to apply for registration following a period of induction into the service.

Staff told us they felt well supported by the registered manager, and confirmed they were clear about who was in charge of the service despite a new manager being recruited. A staff member said, "We know that [name of registered manager] is in charge, she is really good. She is laidback and approachable." They added, "She is on the floor quite a bit too and likes to see what is going on." The registered manager was also supported by a deputy manager.

Audits had been carried out, including audits of care plans which had recently commenced. Care plans were regularly reviewed and evaluations we saw were up to date.

Surveys were carried out and people and their relatives were invited to meetings in the service three times yearly. It was reported that meetings were not always well attended but minutes were sent to people unable to attend. A newsletter had also been developed to increase opportunities to update people unable to attend meetings about what was happening in the service.

We spoke with a relative who told us, "I haven't been to any meetings but I saw surveys in the porch. To be honest I would just speak to the manager if I had any problems." Another relative said, "I haven't completed any surveys as yet, but I have regular contact with the manager. There is always a nice personal note in with my bill with some feedback, and I would use that as an opportunity to raise any issues if I had any. The manager is very accessible."

Stakeholder surveys sent out included questions about the care of people using the service, the management and staff, premises, and the quality of information provided. There was an option to add additional comments. Records of surveys sent and the returned were kept. The manager advised that they did not receive high returns and they were considering ways to increase the response rates to surveys including leaving a supply in the porch in addition to posting them.

Staff told us that they enjoyed working in the service and that morale was good. The nominated individual was present during the inspection and visited the home on a regular basis. The registered manager told us they felt well supported by the provider.

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 12 HSCA RA Regulations 2014 Safe care and treatment Safe systems were not in place for the storage and administration of medicines. Regulation 12 (2) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective governance arrangements were not in place in order to assess, monitor and drive improvement in the quality and safety of the service. Regulation 17 (2) (a)