Rico Healthcare (Grange) Limited

Grange Nursing Home

Inspection report

18 Grange Drive
Heswall
Wirral
Merseyside
CH60 7RU

Tel: 01513426461

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22 January 2019
23 January 2019

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection was carried out on 22 and 23 January 2019 and was unannounced. Grange Nursing Home was last inspected 16 and 19 January 2018 and was rated Requires Improvement. During this inspection we found that the service had deteriorated.

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

Grange Nursing Home accommodates 32 people in one building and provides care including those requiring nursing care. At the time of inspection there were 19 people living in the home. There are 19 single bedrooms and 5 double bedrooms over two floors, with another 2 single rooms on a mezzanine floor. There are also 3 lounge/dining rooms. A passenger lift is provided for people to move between floors, but the 2 bedrooms on the mezzanine floor are only accessible by a stair lift.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of inspection, the previous manager was in the process of de-registering and the home manager was in the process of registering. The home had no deputy manager in place.

During our inspection, we identified five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulated Activities 2014 in respect of Regulation 9 person centred care; 11 consent, 12 safe care and treatment; 17 good governance and 18 staffing, of the Health and Social Care Act 2014 Regulations. You can see what action we told the provider to take at the back of the full version of the report.

We found that the Mental Capacity Act 2005 and the Deprivation of Liberty (DoLS) 2009 legislation had not been adhered to in the home. We saw that people's mental capacity to make decisions had not always been assessed appropriately, consent had not always been sought and best interest meetings had not taken place when appropriate.

Accidents, incidents and complaints had not been managed appropriately. Audits of the service were ineffective and in some cases not carried out. There was no evidence that external audits had been actioned.

We saw no evidence of a robust induction process into Grange Nursing Home for either permanent or agency staff. Staff had not attended training the provider required them to and there was no oversight of training or induction by the manager or provider.

Care plans and risk assessments had not been updated accurately and in some cases contained

contradictory guidance that if followed would pose a risk to people's health and safety. People's personal emergency evacuation plans did not match their risk assessments.

There were no activities available for people in the home and during the inspection we observed that staff did not always have the time to interact with people. People were not asked what they wanted to watch on the television and we identified staff did not always listen to what people were saying.

People we spoke with, relatives and staff all indicated there were issues regarding staffing levels. We saw that there was a high use of agency staff and that this impacted on the quality of the care being delivered.

Overall, we found the management of the home inadequate.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

•□Ensure that providers found to be providing inadequate care significantly improve.
•□Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
•□Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location from the providers registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Medicines were not safely managed.

People's needs had changed and risk assessments had not been updated. People's personal emergency evacuation plans did not match their risk assessments.

People living in the home, relatives and staff reported low staffing levels.

Monitoring information such as charts for pressure area care/nutrition/fluids were not always completed fully

Is the service effective?

Inadequate

The service was not effective.

People's mental capacity had not been assessed in accordance with the Mental Capacity Act 2005 and appropriate consent processes had not been followed.

It was not always clear if staff had received an induction and training was not effective.

People's nutrition and fluid intake was not appropriately monitored or managed.

Is the service caring?

Requires Improvement

The service was not always caring.

We observed that language was used that was not dignified or respectful.

We observed staff to be caring and approachable.

People appeared at ease with staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some people who lived in the home did not have a plan of care that was appropriate and met their needs.

Care plans did not match with relevant risk assessments and were regularly reviewed but not reflective of changes.

There were no activities available for people.

Is the service well-led?

Inadequate

The service was not well-led.

Quality assurance systems in place to monitor the quality or safety of the service were ineffective.. This placed people at risk of potential harm.

Records were not accurate and complete in respect of each person living in the home.

There was a lack of communication between staff and manager.

Grange Nursing Home

Detailed findings

Background to this inspection

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

The inspection was prompted in part by information shared with CQC by the local authority regarding the management of the home. The Commission had also received notifications from the public concerning staffing, care and potential concerns about the management of risk. This inspection examined those risks.

This inspection took place on 22 and 23 January 2019, this inspection was unannounced.

The inspection team consisted of one adult social care inspector, two medicines inspectors, a specialist professional advisor (SPA). The SPA was a registered nurse with experience of the care of people with dementia. An expert by experience also attended the inspection. An expert- by- experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we asked for information from the local authority and we spoke with Healthwatch Wirral for any additional information about the home. We reviewed the information we already held about the service and any feedback we had received.

During our visits we spoke with four people who used the service, five people's relatives and five members of staff. We observed care being delivered in the lounge and at lunchtime. We looked at care notes of eight people who used the service, medication storage and records, four staff records, accident and incident report forms, health and safety records, complaints records, and other records relating to the management of the home.

At the time of the inspection there were 19 people living at the home and 30 staff employed.

Inadequate

Is the service safe?

Our findings

People and their relatives we spoke to told us they felt safe in the home, however during the inspection we found concerns about the safety of the care being delivered.

Medicines were not managed or stored safely. Medicine cupboards were neat and clean but creams only available on prescription were left in people's rooms. Two of these creams should have been stored in a refrigerator to ensure they remained effective. The medicines fridge in the treatment room was unlocked and a member of staff who was not trained to handle medicines had unsupervised access to the room. Medicines inside the fridge and treatment room were kept at the right temperatures.

Neither the application of moisturising creams nor medicated creams was recorded. This meant the provider was unable to demonstrate creams were applied safely or people's skin was cared for properly.

Arrangements for storing and recording controlled drugs (medicines subject to extra control because of the risk of misuse) complied with the law. However, nurses did not check and record stock balances on a regular basis. This would be good practice as it reduces the risk of mishandling or misuse. Medicines (including controlled drugs) no longer required were not disposed of promptly. This increases the risk of a medicines errors occurring.

We saw that staff gave people their medicines in a friendly way and signed the medication administration record (MAR) after administration (with one exception). However, medicines were not always given at the right times. For example, one person prescribed a medicine to treat Parkinson's disease was given their medicine more than an hour late. Giving this medicine at the time prescribed is important for the person's well-being. At a recent hospital appointment, the specialist had recommended that this person's dose of Parkinson's medicine was increased. The person was not receiving the extra doses and the home had not contacted the GP for their instructions.

Some people were prescribed one or more medicines to be taken 'when required'. Guidelines on when to give these medicines (protocols) were kept with the MARs. However, protocols had not been reviewed since December 2017 to make sure they were up to date. We saw that one person had protocols for two medicines they were no longer prescribed.

The manager told us they had not yet assessed the competency of nurses employed by the home to administer medicines (the manager was appointed in September 2018). They had carried out a medicine audit in December but no actions were taken to improve the way medicines were handled. We asked the manager to send us a copy of the home's medicine policy, this was received following the inspection.

These were breaches of Regulation 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the care files for eight people and found concerns with each of them. Monitoring information

such as charts for pressure area care, nutrition or fluids were not always completed fully and in some cases, were added to during inspection. For example, a fluid balance chart from the previous evening was added to mid-morning on the first day of inspection. This was done by the nurse who was still in the building from the previous night. We saw that one person required a pressure relieving mattress, which had directions for the settings to be appropriate for their weight, there was no record of this being checked regularly.

We found that reviews of risk assessment were ineffective. The home had people living there with complex needs. Some files noted 'no change' for up to and over 12 months. We found a discharge letter for one person from December 2018 that stated the person had a specific health problem. This had not been identified in any risk assessment and so indicated that no one had read this information and put any actions in place to minimise risk.

We looked at people's personal emergency evacuation plans (PEEP) and found these were inadequate. The information held in people's risk assessments/care files did not match their PEEP's. An example of this was how one person was to be evacuated in a specific way, this was not reflected on their PEEP and reviews of PEEP said, 'no change' for a significant number of months. Another person's care plan stated a person was to be repositioned two hourly to prevent pressure ulcers. We observed no one going into the room before 12pm on the 1st day of inspection. This person was at a high risk of skin break down.

There had been no accidents and incidents reported since August 2018. However, one person's daily notes stated an accident form had been completed for an injury that had occurred in November 2018. There was no evidence of this and the home manager had no knowledge of the form. The injury had been ongoing since November 2018 and there were no care plans or body maps in place.

We identified that one person had very specific foot care needs. The persons care plan contained no evidence of care of feet for example cleaning, drying and monitoring. We saw that an ulcer was discovered by a visiting podiatrist and subsequently treated. This had not been identified and/or acted on by staff in the home.

These were additional breaches of Regulation 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our last inspection we identified some issues surrounding maintenance of the premises. At this inspection we found improvements in the monitoring of maintenance issues however, some water temperatures still exceeded the recommended temperature for water in a care home. High water temperatures (particularly temperatures over 44°C) can create a scalding risk to vulnerable people who use care services.

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

During our inspection we saw the home was clean, however parts of the décor were very worn and shabby. Some equipment such as a shower was out of order, areas where items of furniture had obviously been removed and the area behind had not been painted, gave an overall impression of unkemptness. We also observed outside the dining room window there were quantities of broken appliances, a wheelchair and several zimmer/walker frames. This did not look very pleasant and was the way people living in the home entered the garden area.

The dining room appeared to be an area where items were being stored, there were three walking frames

and a wheel chair. The dining room was a bright, pleasant area and seemed to have been re furbished and painted. Unfortunately, it was not being used at all by people living in the home on either day of the inspection.

We asked people and their relatives about staffing in the home received negative responses. Comments included "Not enough staff they are run off their feet, no personal time for the residents. I use my call bell all the time, it varies as to how long it takes to answer" and "They are short of staff all the time." Relatives also told us "I am concerned at the amount of agency staff being used and the lack of staff all round." Another said, "They have never got enough staff."

We looked at rotas for the previous four weeks and saw that there was a high number of agency staff being used. This included both nurses and care staff, this mean that at times the amount of staff on duty and their knowledge of the people living in the home did not meet the dependency needs of the people living in the home. On the second day of inspection there was one agency nurse on duty, to agency staff and one permanent care staff. We were told that the staff were unfortunately running late as the permanent care staff member was having to show the agency care staff what to do.

We looked at the recruitment processes and found that there were appropriate systems in place. We saw completed application forms and references. We saw that all staff in the home had a Disclosure and Barring service (DBS) check completed. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with children and vulnerable adults.

Inadequate

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to 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).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The service was not working within these principles.

Best interest's information was inadequate. Examples included a document showing that the previous manager had signed to say they were acting in a person's best interests. A best interest meeting in consultation with relatives had not been held. This decision had also not been audited/reviewed. We saw that some care files did not have consent in them at all. One person was assessed as having capacity to consent to the use of bedrails and not using their call bell, but deemed not to have capacity to consent to staying in the nursing home. This was contradictory. Also, there were no other documented discussions or decisions around less restrictive options in keeping the person safe and we identified that there were inadequate mental capacity assessments.

These were breaches of 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were told all staff had received an induction when first employed by the service, however this was not apparent. We asked for induction records for staff in the home however we were supplied with induction records that were dated 2015 and 2013. This did not show the current staff inductions. We also saw there was no evidence of agency staff induction.

On the second day of inspection there was one permanent care staff and two agency staff who had not visited the home before. There was no structure to their introduction as the care staff had to 'show them what to do'. The home manager was asked about the process; however, no evidence was provided to show any structured induction into the home. We were told by the home manager that staff had three days shadow shifts and a work book to completed, however there was no evidence of this in practice. We also saw no evidence of ongoing monitoring throughout a probationary period even though this was asked of the home manager during the inspection who was unable to tell us any process.

We looked at the training provision for staff. The manager had a training tracker in place which showed the training that had been attended by staff. This showed staff had not attended training deemed mandatory by the provider. We also identified that two staff who had been employed for over three months had not completed the training that was meant to be part of their induction. This included safeguarding and manual

handling.

These were breaches of 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed lunchtime on both days and saw that there were no menus displayed. On both days of inspection lunch was due to be served from 12.30pm, no one sat at dining tables, three people sat in armchairs in the lounge area and other people had their lunch served to them elsewhere in the home. On day one the food did not start to leave the kitchen area until 1.15pm and the chef kept coming out from the kitchen area to look for staff to start the dinner service. The people in their bedrooms were served first.

Three people sitting in the lounge were served their lunch at 1.20pm. Two of the people had their food placed before them and did not touch it and were not encouraged. We left the lounge at 1:37pm and their food remained untouched. We were told they did not require assistance but no encouragement from staff was apparent. The same two people still had their puddings, apple crumble and custard in front of them at 3.00pm, along with cold cups of tea. Throughout the lunch time the television was on very loudly and was quite invasive.

We looked at diet charts during the inspection. These charts are meant to monitor the food and drink a person has throughout the day. These were not updated regularly. We saw how one person's care plan advised of PEG feeding but also that the person could have food orally (soup thickened with powdered milk), however there was no choking risk assessment with this. A PEG (Percutaneous Endoscopic Gastrostomy) is a way of introducing food, fluids and medicines directly into the stomach by passing a thin tube through the skin and into the stomach.

On discussion with staff during the inspection we identified that the person was PEG fed only and nil by mouth. This meant that the care plan was not reflective of needs and ultimately posed risk. The PEG maintenance details held in the person's care plan had been provided by a dietician which had not been translated into the care home's own planning or referenced to in care plan.

One person was meant to have thickener in their fluids however we did not see this being used. We asked staff about this and were told that the person refused to have it. We did not see any documentation to say this risk had been explored or any input from other professionals had been obtained. In discussion with staff they could not confirm that any professionals had been contacted about this matter.

These were additional breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

All of the visitor's we spoke with praised the way the permanent staff dealt with their relative. One said "The staff are impeccable, the original staff. No complaint at all." Another said, "The staff are very good but agency staff do not know their needs." The people living in the home felt the staff listened to them and acted upon what they said, if they had time to listen. One person commented "Yes, if they have time, they are always busy."

All of the relatives we spoke with said their family member was treated with dignity and respect. All said their family members were clean and tidy at all times. However, we observed that staff used language which was not dignified or respectful. We heard one staff member comment "I'll go and do 'the feeds" when those who needed support with eating were ready to be served.

Three visitors we spoke with had been involved with care plans and some knew the names of some of the permanent staff and the jobs they undertook. One visitor said "My relative is supported with all their needs. They wash and dress them and give them the odd shower. They treat her with dignity at all times."

One person said "I can have a shower when I want to, the staff help me. I get up and go to bed when I want to. I dress and undress myself to stay independent." Another person told us "I have a shower every morning and the carers help me and treat me with dignity. The agency staff are not as good and sometimes I do not like the way they clean me, I feel undignified."

We were not able to see a 'Service user Guide' for Grange Nursing Home during the inspection. This is a document that should provide information for people and their relatives if they were wanting to move into the home. However, the home had a Statement of Purpose in place that contained incorrect information. A Statement of Purpose is where a business describes what they do, where they do it and who they do it for. The document held information that discussed activities, staff training and care plan reviews. These were not taking place at the time of inspection.

We saw that a relatives meeting had taken place in October 2018 and that suggestions made had been acted on. Examples included new cups, where the signing in book is located and the replacement of a towel dispenser.

However, during the course of the inspection, we were aware of a number of incidences that were not recorded or potentially responded to safely and appropriately. This meant that staff working at the home did not always recognise people's diversity. There were occasions where staff had omitted to respond to people's needs or provided information or support and this potentially impacted on the wellbeing of people living in the home.

During our inspection, we used a method called Short Observational Framework for Inspection (SOFI). This meant we could observe staff interactions with people who were unable to verbally communicate. We observed that staff were not able to interact with people living in the home regularly due to staff shortages

and being too busy. We observed the people sitting in the lounge had little to occupy them and the television did not have engaging programmes on it.

Requires Improvement

Is the service responsive?

Our findings

The home had no activities available at all. On the second day of inspection a member of the inspection team sat in the lounge all day. where a programme about wedding dresses was on the television all day. Staff did not come in or ask if people wanted to watch another channel or a film. One person told us "No activities in the home but it is supposed to be going to change. I would take part if there were something going on." One relative told us "There's nothing going on, it's just flat."

We saw how one person was helped into the lounge at 1:10 pm after being helped out of bed at this time. and they asked for cereal as they had just got up. We observed a staff member place a full meal in front of them and they obviously did not know this person had just got out of bed. When he asked again for cereal the staff member did not listen to them and told them "Oh no this is better for you". The inspector raised this with the administrator who went to see what had happened. This was then rectified and brought to the manager's and provider's attention.

Information had not been handed over to care staff about a person who was to receive a visit from an optician, this meant the person was not ready to have their appointment and was actually still in bed. The inspection team were told that everything was running late due to the agency staff on duty needing to be told what to do by the one permanent care staff on duty.

These were breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at eight care plans and saw that all were out of date, some had not been reviewed since March 2018. All care plans acknowledged if a person had a mental health need however, showed limited depth and clarity of being able to manage dementia and complex mental health. Care plans did not match with relevant risk assessments and were regularly reviewed but not reflective of changes, 'no change' was recorded on care plan reviews over extended period of times. This meant that staff did not have up to date guidance on how to support an individual appropriately. With the large use of agency staff this meant that there was a high risk of people not receiving person centred, responsive and safe care.

These were additional breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had a complaints policy that was on display for people to access. This was displayed at the entrance to the building making it easily accessible for everyone. We asked people if they felt they could raise concerns and everyone said they could. We were told by two visitors how they had complained to the provider however during the inspection we did not see any documented evidence of the complaint or the outcome. Following the inspection we received information from the provider that showed records of these complaints. There was no other evidence of any complaints to the manager.

We were told there was no one receiving end of life care at the time of inspection, however we did not see

any evidence of any discussions to ensure that the person's wishes were at the centre of their support. It ensures that the person themselves is at the heart of the process, with other people such as relatives and care professionals included and operating in a co-ordinated way.

Inadequate

Is the service well-led?

Our findings

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider had recently appointed a new manager who had submitted an application for registration with CQC. The service did not have a deputy manager in place and in the manager's absence the administrator was the person who staff went to with any problems.

As the service is a home which provides nursing care, clinical oversight is needed over the day to day running of the service. At times this was inadequate as the administrator was not qualified in nursing.

We saw that an external audit had been carried out by infection control however, there was no evidence that any of the findings had been actioned. An external fire risk assessment had also been carried out in March 2018 and during the inspection the maintenance person had to read through the report to see if actions had been taken. Some issues t found had been actioned, however there were high risk issues still not acted on. This was brought immediately to the manager's attention.

We found that four care plans had been audited since October 2018. These audits of care plans were not effective due to issues previously identified. The audits had identified problems with care plans however no actions had been carried out to remedy it. We saw there were no target dates, completion dates or people responsible to complete the actions. There were no other audits in place, for example monitoring information such as turn charts, nutrition/fluid charts or daily logs. We asked for medication audits and we received one at the end of the inspection. This was not adequate as we found significant issues with medicines.

Induction and training processes were not robust, there was no oversight of care being delivered as there had been a lack of knowledge about the changes to people's needs including those coming out of hospital. There was a lack of communication between staff and manager as we found evidence of non-reporting of issues such as accident forms and changes to the needs of people living in the home.

With the managers lack of knowledge of incidents that may have happened, lack of oversight of the service and inadequate audits in the home, we could not be certain that the Commission had been notified of significant events as is required.

These were additional breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider said they had policies and procedures in place, these covered subjects such as complaints, health and safety, medication, safeguarding and recruitment. We requested that these were sent following the inspection and we received them.

During and following this inspection we shared our findings with the local authority commissioning and safeguarding teams.

From April 2015, providers must clearly display their CQC ratings. This is to make sure the public see the ratings, and they are accessible to all of the people who use their services. The provider was displaying their ratings appropriately in a clear and accessible format at the entrance to the home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider was not delivering person centred care.