Oldbury Grange Nursing Home Ltd

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 22 and 23 March 2017. The visit was unannounced on 22 March 2017 and we informed the provider we would return on 23 March 2017. We gave feedback about concerns we had identified to the registered manager and managing director on 23 March 2017. Two inspectors returned, unannounced, on 4 April 2017 to check if immediate actions had been taken by the registered manager to address issues we identified.

Oldbury Grange provides accommodation, personal and nursing care for up to 89 older people. The home has two floors; the ground floor provides nursing and residential care to older people living with complex health conditions. The first floor has two units; one nursing and one for people living with dementia. The home provides end of life nursing care to people. At the time of the inspection 79 people lived at the home.

The home is required to have 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. At the time of this inspection the home had a registered manager in post, who is also the nominated individual of the service.

When we inspected Oldbury Grange in January 2015, we found breaches of the regulations relating to cleanliness and infection prevention and control and staffing levels, we gave a rating of 'requires improvement.' At our last inspection in May 2016 we found some improvements had been made and the regulations were met. However, further improvements were required and we gave a rating of 'requires improvement.' We asked the provider to send us a report to tell us what action they had taken to make further improvements. We received an action plan from the registered manager, and the managing director telling us about improvements that had been implemented.

At this inspection we found planned improvements had not been made or sustained.

Risks to people's health and welfare had not always been identified or assessed and actions to minimise the risk of harm or injury to them had not been taken. Where risks to people had been identified, actions for staff to take to minimise those risks were not detailed which meant staff did not have the information to tell them how to minimise identified risks of harm and injury to people.

Accidents and incidents were not always reported or recorded in a consistent way. Where people had sustained injuries, such as from falling, their 'falls risk assessment' was not reviewed by staff to determine ways to reduce the risk of further falls.

The provider did not have suitable arrangements in place to deal with emergencies that might arise from time to time. Some people did not have a personal emergency evacuation plan in the file we were told would be given to the emergency services. The registered manager informed us they did not have enough

first aid qualified staff to ensure there was a staff member on each shift who was competent to deal with first aid emergencies that might arise.

The provider did not have a safe system of recruitment in place. Checks had not always been carried out on people working at the home to ensure they were of good character. Where checks had been completed on workers and identified a potential risk, we found risk assessments had not been completed by the registered manager.

Overall, staff felt there were enough of them on each shift. However, some people felt more staff were needed and we observed there were not always sufficient numbers of suitable staff to keep people safe and meet their individual needs.

Staff told us they understood what constituted abuse and would report any concerns they had to the registered manager. The matron and registered manager, overall, knew what abuse was and generally sent us the required statutory notifications.

People had their prescribed medicines available to them. Overall, people were given their medicines by nurses following safe practices. However, we observed an example of poor practice when one nurse gave an administrative office staff member three pots of medicines to give out. Records of controlled drugs made by nursing staff were not always clear.

Staff received training, however, this was not always effective in giving staff the skills they needed to effectively fulfil their role. Staff had a limited knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. This meant some staff were not aware of their responsibilities under this Act.

People told us they enjoyed their meals. We saw nutritious meals and high calorie snacks were offered to people and supported people when needed. However, we observed people did not consistently receive support or prompts to drink.

People were supported to access healthcare services, such as GPs and chiropody, to maintain their health conditions and wellbeing.

People and relatives felt staff 'did their best' and had a caring attitude. Our observations showed staff did not consistently show a caring approach and did not always promote people's dignity.

Overall, staff met people's physical needs. However, this was not personalised and people's needs were not always responded to on an individual basis.

Relatives told us they knew how to complain. A few relatives told us they felt issues raised were not always resolved to their satisfaction.

People's care records were sometimes not sufficiently detailed to support staff to deliver care in accordance with people's needs and wishes, and staff were not always able to tell us about people's needs.

Audit systems and processes to monitor the quality and safety of the service were not effective in identifying where improvement was needed. There was insufficient oversight from the registered manager to check delegated duties to senior staff had been carried out effectively. This meant that people experienced a number of shortfalls in relation to the service they received.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The overall rating for this service is 'Inadequate' and the service is therefore in 'Special Measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this time frame. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

You can see what action we have taken and 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?

Inadequate

The service was not safe.

Risks of harm and injury to people were not always identified and when they were, actions to minimise those risks were not always in place or followed by staff. Staff did not have the knowledge to deal with emergencies

The provider did not have a safe system of recruiting staff and checks were not always undertaken to make sure staff were of good character before they supported people who lived at the home.

People had their prescribed medicines available to them but a safe administration system of medicines was not consistently followed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had undertaken training to deliver care and support but their competencies to undertake their job role were not always effectively assessed. Staff had a very limited knowledge of the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People enjoyed their food but were not consistently given the support they needed to eat and drink.

People were supported to maintain their health and were referred to health professionals.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Most people and their relatives told us that staff were kind and caring towards them or their family member. However, we observed inconsistencies in staff approaches and times when a caring approach was not always shown toward people.

People's dignity was not always promoted by staff. People were not routinely supported to express their views or be involved in decisions about their care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive care that was personalised to them. Staff did not always prioritise people's needs above other non-care tasks, such as writing care notes. Initial assessments of people's individual needs were not always completed and care plans were not detailed to support staff in delivering safe care and support in accordance with people's individual needs.

People and their relatives did not always feel concerns raised were satisfactorily resolved.

Some group social activities were offered to people but these were limited and staff did not have enough time to fully support people's emotional and social well-being.

Is the service well-led?

Inadequate

The service was not well led.

The provider's systems and processes to monitor the quality and safety of the service were not effective in identifying where improvement was needed. This meant that people experienced a number of shortfalls in relation to the service they received. There was a lack of management leadership and oversight which resulted in a culture that was task led and not focused on the people who lived at the home.

Oldbury 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 took place on 22 and 23 March 2017. The visit was unannounced on 22 March 2017 and we informed the provider we would return on 23 March 2017. The inspection team consisted of three inspectors and a specialist advisor on the first day of the inspection visit. A specialist advisor is someone who has current and up to date practice in a specific area. They advise CQC inspection teams but are not directly employed by the CQC. The specialist advisor who supported us had experience and knowledge in providing skin care to older people living with complex health conditions.

Two inspectors returned on the 23 March 2017 to continue the inspection, during which time, we gave feedback to the registered manager and provider about concerns we had identified. Two inspectors returned, unannounced on 4 April 2017, to check if immediate actions had been taken to address some of the concerns identified.

The provider had previously completed a provider information return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Prior to this inspection, a request for a new PIR was not made. Since our last inspection in May 2016, the provider had sent us an action plan telling us about the improvements they had made. During this inspection, we gave the registered manager an opportunity to supply us with information, which we then took into account during our inspection visit.

At our last inspection in May 2016, we were aware of a police investigation into an incident at the home in February 2016. In January 2017, we were informed by the police that the investigation had been concluded

without further action.

We reviewed the information we held about the service. This included information shared with us by the local authority and notifications received from the provider about, for example, safeguarding alerts. A notification is information about important events which the provider is required to send us by law. Prior to our inspection visit, we had received some information of concern from members of the public about the care provided to people who lived at the home.

We spent time with people and saw how they received care and support. This helped us understand their experience of living at the home. 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 with us.

We spoke with 15 people and spent time engaging with people who lived at the home. We spoke with 11 relatives who told us about their experiences of using the service. We spoke with staff on duty including 11 care staff, three nurses, two cooks, one maintenance staff member, one activity staff member, the care co-ordinator, the matron, and the registered manager. We also spoke with the managing director of the provider company who is also a doctor providing GP support to people at the home. We spent time with and observed care staff offering care and support in communal areas of the home. We also spoke with three ex-staff members who had recently left their employment at the home.

We reviewed a range of records, these included care records for 15 people, seven people's wound and pressure area management plans and 15 people's medicine administration records and five staff employment files. We looked quality assurance audits and feedback from people.

Inadequate

Is the service safe?

Our findings

At our inspection in May 2016, we identified that whilst risks associated with people's care were assessed, actions were not always put into place to reduce the risk of harm. Staff did not always have the training, skills or information they needed to keep people safe. We rated this domain as 'requires improvement' and asked the provider to send us an action plan on how improvements would be made. An action plan was sent to us telling us about improvements made. However, at this inspection we found insufficient improvement had been made and identified further concerns relating the safe care and treatment of people.

In May 2016, we identified a risk of harm and injury to people from a large boiling water urn that was left unattended by staff on a 'tea trolley' in a communal lounge. The registered manager told us improvement would be made immediately to reduce the risks. They told us they would ensure a designated staff member, on each floor, did not leave the tea trolley unattended. However, on this inspection we saw the boiling water urn was left unattended. People living with dementia walked close to the urn full of boiling water, and on occasions held on to the tea trolley as they walked past it. This presented a continued risk to people.

Risks to people's safety had not always been identified or assessed and actions to minimise the risk of harm or injury to them had not been taken. Radiators in communal lounge and dining areas were so hot they could not be touched for more than a few seconds without there being a risk of burning. A lounge used by people who lived with dementia was left unattended by staff, and people were sat close to two very hot radiators. These, and other radiators in the home, posed a potential risk to people's skin being damaged.

Two people who lived at Oldbury Grange smoked cigarettes and one person's care notes recorded an incident of them smoking in a bathroom in the home. Staff had recorded this was because the person 'forgot' they were meant to go outside. This potentially put this person and everyone at the home at risk because the bathroom was not a designated smoking area and contained combustible waste in the bins.

One person that smoked cigarettes showed us a burn mark on their hand and told us this was from their cigarette, they indicated to us that their hands and arms were very jerky due to their health condition. They also showed us numerous cigarette burn holes in their tee-shirt and coat, which they had been unable to prevent from happening due to their jerky movements. During our inspection visit we saw both people who smoked cigarettes go outside, unsupported or observed by staff, to an area not overlooked from within the home and with no means of gaining staff attention if needed. The matron and registered manager told us they were unaware of any cigarette burn holes to this person's clothing and a risk assessment had not been completed because they had not realised one was needed.

Risks to people tripping over items were created by staff. For example, we saw maintenance equipment including a ladder, left leaning against an unoccupied bed in one person's bedroom. The bedroom door was open and people living with dementia were in the adjoining communal areas and corridor. Staff left a microphone and cable wire trailing on the floor, around people's armchair legs following a karaoke activity. A bowl full of water had been left on the floor of one person's ensuite. Staff had not identified the risks posed

to people in leaving items unattended.

Equipment in place to reduce risks of damage to people's skin was not routinely checked by staff. There was no record to show that people's special beds, pressure relieving mattresses and cushions were checked to maintain people's safety. Staff, when asked, did not know settings pressure relieving equipment, such as airflow mattresses, should be at for each individual and there was no information available in people's care plans to inform them. The matron and registered manager told us they were unaware that airflow mattresses should be set according to a person's body weight. We looked at two people's weight record and found their special pressure relieving mattresses were on 'comfort settings' that were too high for their individual weight. This meant that risks of people's skin becoming sore or damaged were not effectively managed.

Risks of people falling were identified. However, actions to minimise those risks were not detailed which meant staff did not have the information they needed to reduce risks of harm and injury. For example, one person's 'mobilising care plan' told staff to 'supervise closely whenever [person's name] is mobilising as they are at very high risk of falling.' Throughout our inspection, we saw this person was not always observed by staff. We asked one staff member what level of 'supervision' the care plan meant and they told us it meant to 'keep an eye on the person when you could.' This did not effectively minimise identified risks of falls and staff were unsure about what was meant by 'supervise closely'.

We identified three people at immediate risk of falling and staff were not present to offer support when needed to keep people safe. Falls risk assessments identified these people were at 'high risk' of falls and records showed they had had recent falls. We discussed this with staff and they told us staff members did not always stay in communal dining and lounge areas throughout the shift because they were busy attending to other people or tasks. This meant that people described at 'high risk of falls' were left unattended by staff for periods of time throughout each shift and actions to minimise those risks were not taken.

We discussed people's risk of falls and measures to reduce these risks with the matron. They told us when people sustained a fall, if there was no apparent injury requiring immediate medical attention, they ensured the person was checked by the GP and some referrals had been for guidance from the 'falls prevention team.' The matron agreed that other measures, apart from staff observation, had not been considered to reduce people's risk of falls.

Accidents and incidents were not always reported or recorded in a consistent way. For example, one person's care plan had some falls recorded in daily notes, some on their falls risk assessment but dates of falls did not always correspond. This person's falls risk assessment had not been reviewed in the days following numerous falls, this meant opportunities were missed to reduce risks of this person sustaining further falls. The matron agreed that the person's risk assessment was not reviewed in the time period following falls and the person had sustained further falls. We found there was no guidance available to staff on how to 'score' the falls risk assessment tool. The matron and registered manager were unable to inform us how the tool should be used to accurately assess people's risk of falling so that measures could be taken by the provider to enable staff to reduce the risk of people falling.

The provider did not have suitable arrangements in place to deal with emergencies that might arise from time to time. For example, we were shown a file and told this would be given to the emergency services in the event of a fire. Some people did not have a personal emergency evacuation plan (PEEPs) in the file and numerous named individuals on personal emergency evacuation plans were those for deceased people. The matron agreed that the information was not up to date and told us they had not had time to do this to

ensure information was up to date.

The care co-ordinator informed us, "I'm the first aider, I did my training last year and I also teach all the staff first aid." We gave them some first aid scenarios such as a person choking and asked them to describe the first aid action they would take. The designated first aider was unable to tell us the safe first aid response to the scenario given. A nurse told us they would 'tap someone on the back' but could not add any further detail to their first aid response. We identified our concern to the registered manager and they informed us they felt nurses would be competent and would phone 999 if needed. However, the registered manager added they did not have enough staff that had a current first aid certificate to ensure there was such a staff member on each shift.

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

The provider's recruitment practice was not always safe and did not ensure risks to people's safety were minimised. Of the five staff files looked at, all showed that a check had been completed with the Disclosure and Barring Service (DBS). However this had not always been completed by the provider, who had, on occasions accepted previous employment DBS records. The DBS is a national agency that keeps records of criminal convictions. One worker's DBS contained information where we would have expected to find a completed risk assessment but the registered manager informed us this had not been done.

One care staff member's application form, references and DBS were dated 2015, this staff member had left the provider's employment and later returned to work at the home after a period of over 12 months later. The registered manager confirmed to us that on this staff member's return, they had not undertaken any new checks to determine whether the staff member could still be considered safe to employ.

We also found the provider had accepted a DBS dated 2015 for another member of staff who had started their employment in February 2017. No risk assessment had been completed. We found references were not always from worker's most recent employment and were sometimes from close relatives.

We asked care workers about the home's recruitment practice. One care worker told us, "This is my unpaid trial shift today. It's going really well; yesterday I had an initial meeting with the manager and care co-coordinator, but have not yet completed any application form or checks yet. I have not had my induction training, but have been shadowing care staff all morning, watching personal care and meeting people. I've been feeding people at lunch time." The matron informed us they did not know this care worker was on shift. The registered manager told us, "Over about the past six months or so, we've operated a system of unpaid trial shifts so carers interested in working here can experience it before we actually employ them. We've had so many come and go and it's a waste of time and paperwork doing staff files and checks before we know if they like it or not." The registered manager confirmed to us that they had not undertaken any checks to determine whether the care worker was suitable and risk assessments had not been completed for care workers on trial shifts. They told us they were unaware of the care tasks, such as supporting a person to eat their meal, that this care worker had undertaken.

Prior to our inspection we had received concerns from staff who told us they had not been given contracts of employment from the provider. One ex-staff member told us, "I worked at the home for a year and never had a contract of employment." Of the five staff files looked at, none had a contract of employment. We discussed this with the registered manager and they told us, "Some staff don't have a contract of employment yet. We are due to re-issue them in April 2017 because of the new living wage pay rates." A contract of employment is an agreement between an employer and employee and is the basis of the

employment relationship and tells staff what their job role is.

This was a breach of Regulation 19, Fit and proper persons employed, of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014

People told us they felt protected from abuse because 'staff were about in the home.' Staff told us they understood what constituted abuse and gave us examples of what they would report to the registered manager. One staff member told us, "I would speak with the management if I thought there was abuse or go to safeguarding." The matron and registered manager, overall, knew what abuse was and generally sent us the required statutory notifications. However, they gave us an example of an incident that had occurred that should have been reported to us and the local authority. The incident was dealt with internally by them but meant the matron and registered manager did not always identify when safeguarding incidents should be reported.

We asked people about staffing levels at the home and received mixed feedback. One person said, "The staff are a bit rushed, but always try their best." Another person said, "There are not enough staff here." Overall, most relatives felt there were enough staff on day time shifts to safely meet their family member's needs. However, some relatives felt concerned that communal lounges were not always staffed. One relative told us, "The night care shift start at 9.30pm and there are only two care staff on each floor and one nurse shared between both floors. Twice, when I have been leaving from visiting, I have found people on the floor in one lounge and had to get staff." We observed people were left unattended in communal areas throughout our inspection visit and most of these people were unable to use a call bell point to gain staff attention if needed.

One person we observed was crying because they felt 'trapped.' This person wished to leave the dining table and found they could not get out because another person's large reclining armchair had been placed in their way by staff, however, staff were not available to move the armchair when needed.

Some staff felt there were enough of them on shift, although others felt there were insufficient levels of staff to meet people's individual needs. One staff member told us, "More staff would make it safer (for people) here." Another staff member said, I don't think we have sufficient staff, people have to wait. Both floors need extra staff." Staff meeting minutes from January 2017 showed staff had raised this to the registered manager and they told us they had responded by putting extra staff on shift already.

The registered manager told us people's dependency levels were assessed and showed us a list, dated March 2017, of people's names under the headings of 'low, medium, high and very high.' The registered manager told us this was used by them to determine staffing levels. We asked how some people had been assessed as 'medium' when they were cared for in bed and required support in all aspects of their care. The matron and registered manager said they did not use any specific tool to calculate dependency levels but based it on what they knew about people, however, the managing director informed us the 'Isaac Neville standard dependency assessment tool' was used. We found that the provider's 'dependency chart' was not effectively used by them to determine staffing levels needed. For example, people living with dementia and identified at 'high risk' of falls were listed under the heading of 'high dependency' but we saw staffing levels did not facilitate a staff member to stay in communal areas to support these people and keep them safe.

We found there were on-going changes in the care staff team and some staff did not yet know people well or what their individual needs were. One staff member told us, "There have been some good staff leave and go to work elsewhere." One relative told us, "Staff change so quickly, there is no continuity." Another relative said, "The carers are very good and they look after people, but they don't stay long enough." The registered

manager told us they did not use agency staff at the home and preferred to offer extra shifts to existing nursing and care staff to cover shifts if needed so that people had continuity of care staff. The registered manager informed us there were no current staffing vacancies and shifts were fully covered. They acknowledged there was, at times, a high turnover of care staff, and said, "In this type of work, care staff seem to come and go. Some go and then decide to come back."

The staff rota did not always reflect the actual staff on shift. For example, during our inspection visit, one staff member was listed for an afternoon shift but was working before the time their shift was due to commence. This staff member told us this was because "[staff member] loved their job and came in early to start to help out." A further example was the care co-ordinator whose start times for their shift were on the rota but no completion time was given. This staff member told us, "I usually end up staying all day and even evenings at times. I fill in the time on the rota when I go." This was not effective rota planning and we discussed this with the matron and registered manager. The matron told us, "I'll implement a staff signing in book. I agree it is hard to see at a glance who is on shift and the rota should be a bit clearer with shift times for everyone."

We looked at the provider's systems for the safe management of medicines. Prior to our inspection, a local authority staff member shared information with us following their 'spot check' visit they had completed for one person living at the home. We were told this person had not received their prescribed medication for 'at least a week' and staff could not offer any explanation for this not being given as prescribed.

We looked at 15 people's medicine administration records (MARs) and found that these had been completed accurately to show people had received their medicines as prescribed. We observed one nurse administering medicines to people safely and all nurses spoken with were familiar with current guidance relating to the safe administration of medicines.

However, on the first morning of our inspection we saw an administrative office staff member, who told us they were the 'business development manager' with a tray of three pots of medicines. We observed this staff member administer medicines to one person and they told us, "This person is more likely to take medicines from me than the nurse in charge of giving people their medicines. I've been trained to administer medicines." Whilst the nurse was in the same room, they were not directly observing the administration taking place and this posed a risk of an error occurring. We discussed this with the matron and registered manager who told us this staff member had not completed medicines training, but was going to, and were not aware of this practice taking place. The registered manager told us, "I'll look into that."

Some people had prescribed medicines or topical preparations, such as creams, prescribed to them 'when required.' Overall, most people had information available to inform nurses when these medicines should be given. However, the guidance was not consistently followed. For example, one person told us nurses did not always offer them their 'when required' prescribed mouth gel. We saw this was available in the medicines trolley, but records showed this had not been offered each day. This person's mouth was dry and sore and they told us it would be better to have their gel every day. We discussed this with one nurse, who said they would ensure this was offered as the guidance stated, the nurse explained that if this person had been asleep this might be why it had not been offered to them.

Some people were prescribed medicines known as controlled drugs with specific legal requirements. These were stored safely and available to people as prescribed. Records showed the manufacturer's instructions were followed, when, for example, pain relieving skin patches were applied on to people's skin. Controlled drugs have specific recording requirements and we were shown the designated log book. However, we found a few entries were unclear because medicines of different brand names had been recorded under a

different name. We discussed this recording error with the matron who agreed the record was not clear and told us, "That was my fault; I'll ensure different pages of the log book are used in future." Despite the recording error, people had received their medicines as prescribed.

We looked at the cleanliness of the home and the provider's systems for infection prevention and control. Prior to our inspection, concerns had been raised with us, by staff and relatives, about some people's skin. During our inspection visit, some people told us they had 'itchy or sore skin' and we saw numerous bottles of calamine lotion for individual people. We discussed this with one nurse and they told us, "Some people have been scratching their skin. We've made GP referrals and people have had their skin checked. The manager has made a change in the washing powder now and things are getting better."

Some people and relatives felt the home was clean and well presented. However, a few relatives felt improvements were needed. For example, one relative had raised a concern about the lack of cleanliness in their family member's bedroom. We saw some bedrooms had sticky tables and dried stains from drink and food debris.

We found some risks of cross infection because beds, mattresses, pumps for the air mattresses and special chair cushions were dirty with no one allocated to clean or check them. The plastic covering of one person's bed rail bumper covers were cracked which meant effective cleaning could not take place. One person's specialist armchair had a large amount of damaged plastic covering which meant it could not be cleaned effectively and posed risks of cross infection.

The care coordinator showed us a kitchen cleanliness audit they had completed in February 2017, which, overall, recorded cleaning schedules were followed and the kitchen cleanliness was maintained at a safe level. The registered manager showed us an infection prevention and control audit dated January 2017, that had been undertaken by the local Clinical Commissioning Group (CCG). This had scored 84% which meant 'partial compliance' with the standards. The registered manager informed us actions were being taken to make improvements where needed.

Requires Improvement

Is the service effective?

Our findings

At our inspection in May 2016, we identified that improvements were needed to provide effective support to people. The provider had not always fully considered their responsibilities under the Mental Capacity Act 2005. People were not consistently offered choices or given the support they needed to eat and drink. The provider sent us an action plan detailing how they would make their improvements. However, at this inspection we found improvements had not always been made or sustained and staff were not consistently effective in meeting people's needs.

Staff told us they received an induction when they started their job role. One staff member said, "In my induction I was shown how to wash and dress people. I'd say the training was good and I was shown how to do everything properly." However, another staff member told us, "Training could improve. For example, I've been told to put people's hoist slings on in different ways." Whilst most staff felt they had most skills they needed for their job role, our observations of staff practices showed training had not always provided staff with the skills and knowledge they needed to meet people's individual needs in a way that was effective, caring and respectful toward individuals.

On speaking with staff, it was evident they intended well, though lacked knowledge and guidance. For example, at lunchtime we saw a drink of orange squash was poured out into each person's plastic beaker, but staff did not offer any choice of drink to people. One person said they "didn't want it." The member of staff stated they would get them a drink of water. Staff continued to pour the drinks and we heard some people thanked staff for the drink; however, staff did not reply to people or take the opportunity to have a conversation back with people.

The care co-ordinator informed us they trained most of the staff who worked at the home. However, we found they did not always have the knowledge or skills to effectively pass on to staff all of the information they needed to effectively provide care for people based on best practices. We discussed this with the care co-ordinator and registered manager. The registered manager told us they would support the care co-ordinator to update their knowledge where needed so best practices could be passed on to the staff team.

The provider offers specialist care to people living with dementia and their website informs that they "take special pride in our care of residents dealing with dementia, parkinson's disease and the effects of a stroke" Staff were not able to tell us about any specific training they had received, for example, in supporting people that lived with dementia. We did not observe specialist dementia care being provided to people. For example, nine people were in one communal lounge, the television was on with the volume very high and reporting on a news incident that potentially could have caused distress and anxiety. We asked one staff member who had decided which channel was on and why the volume was so high. This staff member told us they "didn't know" but took no action to determine if people wanted this news item on. No one was watching the television and we saw there were no other activities for people to engage with either themselves or with others. Throughout our inspection we saw people that lived at the home sat in armchairs or spent time in their bed and had minimal engagement from staff. One person told us, "Staff walk past my bedroom and look in, but no one really comes to spend time with me."

We asked the registered manager about how nurses maintained their clinical skills, such as caring for people's skin. The registered manager informed us the deputy matron was the lead for tissue viability (skin care). We were informed that the deputy matron, who was on planned leave at the time of our inspection visit, had attended five skin care training sessions at a local hospital and attended link meetings to ensure they had the skills required to provide care for people at risk of their skin becoming sore or damaged. However, we found the frequency of repositioning a person was based on a home routine 'every two hours' rather than following current best practice of repositioning being individualised according to a person's needs and skin condition.

The registered manager showed us their list of people that had pressure areas or other skin damage that was being treated. We found this was not accurate because some people listed had healed skin wounds, for example, whereas others had skin damage that was not listed. Nursing staff did not consistently check wound management charts, for example, charts stated that skin wounds were being photographed but the photographs were not located anywhere in people's care records. This meant that nurses would not always be able to monitor the progress or deterioration of people's skin damage effectively.

The Mental Capacity Act 2005 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 are called the Deprivation of Liberty Safeguards.

Staff told us they would not force people to do anything they did not wish to do. However, they lacked an understanding of the importance of gaining people's consent and how to work within the principles of the Mental Capacity Act to ensure choices were given and restrictions were not placed on people's liberty. Staff could not recall having training on the MCA, although we were told by the registered manager that training had taken place. The registered manager told us they understood their responsibilities under the Act and when, for example, a 'best interests' meeting should take place. However, people's care records did not always reflect this. For example, one person's care records showed an application for DoLs had been sent. This person had bed rails in use, but there was nothing in their care record to say why these would be in the person's best interest and whether it was the least restrictive practice. We saw this person's relative had signed to give 'consent' for staff to place bed rails on their bed, but there was no record of the relative having the legal rights such as power of attorney for health and welfare to make such decisions.

Some people were not offered a choice of meal. The care coordinator told us people were supported to make selections from the menu the week before. A few people recalled this and one person told us, "I find the food pretty reasonable. We get a choice." We asked staff if people that lived with dementia might find it very difficult to recall choices made and staff agreed this might be the case and it would be better to offer visual choices on each day. However, we did not see this happening.

One person told us, "The food is sometimes very good, but sometimes is it overcooked." A further person said, "The food is very good, we get enough." However, a few people who had their meals taken to them in their bedrooms commented that food could be hotter. One person said, "The food is very nice, but it can be luke warm." The care co-coordinator said this was because staff often took two people's plated meals on one tray to save time which resulted in food cooling. The care coordinator or said, "We'll change that and make sure only one meal goes to people at any one time."

Some people were identified 'at risk' of dehydration and malnutrition. We looked at how staff managed this to ensure people who needed support to eat and drink were provided this in a timely way and that systems were in place to effectively monitor people's intake. We found that throughout the day opportunities were potentially missed to encourage drinks and snacks when intake had been low. Those people at risk had recording charts for staff to log what they ate and drank. However, people did not have individual fluid targets to work towards and staff could not tell us what amount people should be supported and encouraged to drink.

One person's nutritional care plan stated, "carer to assist." However, we saw this person had not been assisted by staff. Instead, their meal had been placed on their bedside table by staff, who then left them. This person told us, "Staff always leave me alone." We saw this person had not eaten a food item and they told us this was because "it is too difficult to cut up." Two people's food charts recorded they had eaten 'all' their meal but did not state either what they had eaten or what 'all' actually reflected in terms of the quantity eaten. Drinks were placed next to people by staff at mealtimes and also from the 'tea trolley' mid-morning and mid-afternoon. Staff did not always prompt or support people with their drinks. For example, on the first morning of our inspection, in one communal lounge, five people had full beakers of cold tea next to them. There was no member of staff available to support or encourage them to drink. One staff member said, "I think there is more time at the afternoon tea round to help people."

People's weight was monitored. However, we identified some gaps in checks being made. For example, one person had been admitted to the home in November 2016 and their weight recorded in January 2017, recorded a loss of 3kg and there was no further record of any checks of their weight during February or March 2017. We discussed this with the matron who said this person should have gone onto 'weekly weights' but this had not happened. The matron added people did have food snacks offered to them but agreed this person's weight should have been re-checked. The matron said they would ask a nurse to undertaken that this was done. We saw snacks were available and offered to people in between meals to support their nutritional intake. One staff member told us, "Some people need extra (calories) because they are losing weight." During one afternoon, we saw one staff member supporting people to eat their food snacks.

Some people had healthcare conditions such as diabetes or blood pressure concerns that required monitoring by nursing staff. However, monitoring was not taking place as planned for. For example, one person's 'safety care plan' stated their blood pressure should be checked and recorded on a weekly basis. Between January and the second day of our inspection visit during March 2017, only three blood pressure checks had been recorded. We discussed this with the matron who confirmed weekly checks should have been taking place but said, "I can see the nurses are doing it monthly instead of weekly."

People were supported to access healthcare professionals. During our inspection visit, a chiropodist visited people to support them with their foot care. This healthcare professional told us, "I've got a long list of people to see today. Staff support people individually whilst I attend to their feet." Most people that lived at Oldbury Grange transferred to a local GP practice. Two of the GPs from this practice visited the home on a regular basis, one of whom is also the managing director of Oldbury Grange. One nurse told us they felt supported by GPs that visited the home at least weekly, they told us, "We can fax the GP with a list of people and any concerns and they will visit. Often they come daily to see people." However, healthcare professionals felt they were not always provided with information they needed about people. We spoke with two healthcare professionals and one told us, "One person we are supporting to a hospital appointment is not being escorted by home care staff, but we have not been given any handover information at all about this person. It is not safe practice."

Requires Improvement

Is the service caring?

Our findings

At our last inspection in May 2016, we rated 'caring' as 'good'. During this inspection some people, who were able to speak with us, and relatives made positive comments about the care and support provided and felt care staff were caring. One person told us, "I get good care. I have never had problems." Another person said, "Staff are fine, care is fine." A further person told us, "My care is okay, the staff never argue with me." One person's relative said, "My family member is happy here. The carers are fantastic and they look after my relation." Another relative told us, "The staff do their best."

Care staff told us they felt they had a caring approach toward people. One care staff member told us, "All the carers here are really nice. They've got a good heart."

However, we saw staff did not consistently show a caring approach toward people. Staff frequently walked past people and offered them no interaction. For example, we were sitting in an unstaffed communal lounge with nine people. After fifteen minutes of us being there, one care staff member walked in one door through the lounge and out the other door without speaking or acknowledging anyone.

We spent time observing the care and support people received and this involved us undertaking a Short Observational Framework Inspection (SOFI). We found there was very little staff interaction with those people who had a high level of support needs. One person, who was alert and sitting in a communal lounge, had no engagement from staff from 11.15am to 1.00pm. It was only when this person was given support to eat their meal at 1pm, when staff provided any engagement with them. We saw this person began speaking, however, the staff member was focused on the task of feeding this person their lunch and said, 'Open up,' and at one point we saw the staff member stopped the person talking by putting the spoon to this person's mouth. This did not demonstrate a caring approach and showed staff missed opportunities to speak with people and promote a positive mealtime experience.

On three different occasions, we saw one person had their jumper pulled up over their head so they could not see. We asked staff about this person's behaviour and were told, "It's because [person's name] doesn't like their life." Whilst staff could tell us the reason for this person's action, they did not offer reassurance or try to talk with this person. Another person had pulled her skirt up exposing her legs; we observed one care staff member pulled this person's skirt back down to cover their knees without any interaction with the person.

Staff gave us some examples of how they involved people in making decisions about their care and support, however, these were very limited. For example, one staff member pointed out one person and told us they liked to sit alone in a corridor. We saw that this person sat on a chair in one corridor, although they did not appear anxious, the area was often dark because electric lights were activated by movement and this person sat still. Staff told us this person was content and this was a choice they made about where to spend their time. Another staff member said, "We know some people prefer to stay in their bedrooms and some are cared for in bed." One person told us, "I am happier staying in bed all the time and I can listen to my music or do a crossword." However, another person who staff told us preferred to be cared for in bed all the time,

told us, "I'd like the opportunity to get out of bed sometimes, but I haven't got an armchair that is suitable to support me. So, really I have to stay in bed." This person told us they had mentioned this to staff but were unsure if this had been acted on yet.

People were not consistently supported to express their views and be involved, as far as possible, about making decisions about their care. For example, information for people on how to make a complaint or a certain choice and the annual feedback surveys, was in a written format and this was not accessible to everyone that lived at the home, which meant they could not use the information if they had wanted to. We discussed this with the care co-ordinator and asked whether they had considered visual images so people could make choices about their food or a pictorial 'easy read' feedback survey form for people. They told us these had not been considered but it was something they could do. The care coordinator added that consideration could be given to pictorial feedback form surveys for some people that may find these easier to use than the current written forms that were not given to some people.

Staff told us they knew how to maintain people's privacy and dignity and gave us examples of how they would do this, such as closing bedroom doors when supporting people with personal care tasks. However, in practice, staff did not always follow what they knew and we did not see poor care practices were challenged by other staff members. Staff often spoke loudly about people's support needs in a way that was overheard by others and not as discreetly as they could have been. For example, asking people if they needed the toilet loudly or saying they needed to 'fetch a (incontinence) pad' in front of other people.

Some people were cared for in bed and choose to have their bedroom door open. People told us that most staff knocked the door or spoke to them as they came into their bedroom, but others did not always 'remember to'. We observed an example of this when the maintenance staff member walked into one person's bedroom without knocking or talking to the person.

People's dignity was not always promoted and staff did not always put the needs of people, and their dignity, before other tasks. One relative told us, "I have often visited and found my family member in dirty clothing; food stained and I've asked for them to be changed. I'm not sure staff would do it, if I didn't ask." Another relative told us they had raised an issue about their family member having dirty fingernails and this had later been resolved. However, we identified some people that had dirt embedded under their finger nails. One staff member confirmed one person had already 'had personal care' but their fingernails had not been cleaned. On the second day of our inspection, this person's fingernails remained dirty.

Some people wore poorly fitted clothing and looked unkempt in their overall appearance. For example, one lady had bare legs with stockings around her ankles and a staff member told us, "The elastic has gone." We saw some people's clothing was stained and soiled with food and drink. A team leader who told us, "Some people don't like to get changed." Another staff member said, "The plastic aprons are no good, the tabard ones are much better, but we don't have enough of them for people." The registered manager told us they thought they had enough tabard aprons for people, however a staff member explained when tabard aprons had been used at breakfast time they were not ready again for use at lunchtime, so they felt there were not enough available.

One person felt staff were 'brilliant' but also told us of an incident where they had been incontinent and had asked staff to support them to change, the staff had told them they would return after they had written a care plan..

Staff told us they understood the importance of keeping people's personal information private. We saw records, such as care plans, were kept securely and access restricted to those authorised. However, the care

co-ordinator informed us they used their personal email account to correspond with people's relatives which was not in line with the Data Protection Act 1998. The care co-ordinator informed us they would request a separate email address for work purposes from the registered manager.

Requires Improvement

Is the service responsive?

Our findings

At our inspection in May 2016, we identified that improvements were needed to provide safe care and support to people that was responsive to their individual needs. People's care plans were not always detailed to support staff in delivering care in accordance with people's needs and preferences. Concerns raised by relatives were not always resolved. The provider sent us an action plan detailing how they would improve. However, at this inspection we found improvements had not always been made or sustained and staff were not consistently responsive in meeting people's individual needs.

Peoples and relative's experiences of staff responsiveness to people's needs varied. Some relatives made positive comments to us about how effective they felt staff care for and responded to their family member. One relative told us, "My relation moved here last year and they asked me how they liked to spend their time. I've seen the office lady doing my relation's nails for them. My relation is doing well here, staff spend time with them."

However, other people did not always experience care that was personalised to their individual needs. For example, staff had put on a film one afternoon in a communal lounge for people that lived with dementia. The volume was very high and one staff member said this was so it was "like a cinema," however, they did not consider the impact of this on people and did not stay in the lounge. We saw one person with their hands over their ears and looked distressed. We fetched another staff member and pointed this out, and they said, "I'm not surprised, it's too loud in here" and the volume was lowered.

Initial assessments of people's needs before they moved to the home were not always completed. One relative, who was satisfied with the care their relation received, told us, "The manager did not come and assess my family member before they moved here. The manager told me, 'we are professionals, we don't need to'." This potentially meant people's individual care needs were not given consideration or planned for before they moved to the home.

Where relatives had power of attorney for their family member's health and welfare decisions, there was no evidence to show how they were involved in planning and reviewing their relation's care. One relative told us, "I have, for a number of months, been asking them to arrange a dementia test for my family member but this has not yet happened. I've never seen their care plan."

At our last inspection, we saw one person had their bed positioned directly under a skylight window, which meant bright sunshine shone directly in their face. The registered manager had assured us a blind would be purchased and fitted. At this inspection, we saw there was no blind in place and the same issue remained. The registered manager told us, "I remember buying a blind; I bet no one has put it up."

At our last inspection we also discussed our concerns with the registered manager that people did not always have calls bells within reach so they could use them. The registered manager had told us people should have their call bell given to them. On this inspection, we found when staff left people's bedrooms they did not always check people had their call bell within reach so they could gain staff attention if needed.

One person cared for in bed told us, "They (staff) forget sometimes to give it to me." Some people did not have call bells and the matron explained this was because the call bell cord presented a risk to the person. The matron and registered manager told us they had not given consideration to alternatives, such as pendant alarms, for people but would do so for the future.

The provider's website states that they "run a bespoke programme of activities for dementia in our sensory room." However, we did not observe this or see a designated sensory room. Staff did not have enough time to fully support people's emotional and social well-being and to provide person-centred care. The activities staff member told us they did not know how to provide activities for people that lived with dementia.

The registered manager told us that since our last inspection there had been a change in the staff member designated to provide activities for people and they were planning to arrange training for them. The registered manager said the activities staff member worked from 10.00 – 2pm five days a week, which meant they had 20 hours a week allocated for both group activities and one to one activities for 79 people. The registered manager added that care staff also provided activities to people.

We saw much of the designated activities staff member's time was spent supporting people with drinks and helping at lunchtime. With what time this staff member had left, they offered a karaoke session to people on the first day of our inspection visit, which involved singing nursery rhymes, and coffee and cake mid-morning the following day. Care staff told us they did not have time to offer activities to people and if the designated staff member took some people out on a trip, no other activities took place for people.

The care co-ordinator told us a 'fun day' last year had raised over £700 toward the 'resident entertainment fund' and this was used toward activities and trips out, such as two barge trips that were planned for. A summer fete was also planned for and staff told us this was well attended and popular with people and their relatives.

The provider did not always respond to concerns or complaints received to people's satisfaction.
Prior to and during our inspection visit, a few relatives shared information with us about their concerns that had not been resolved. Since our last inspection, a few relatives had told us they felt issues had not been resolved to their satisfaction and had decided to move their family member to another home. One relative had informed the registered manager that their relative's bedroom carpet had an offensive odour, which we also smelt during our visit. The registered manager told us they were aware of this and had suggested the relative pay for the flooring to be replaced or move their relative to another bedroom. We discussed this with the registered manager and they told us, "I am not willing to replace the bedroom carpet because it is quite new." The relative told us their family member was settled in their bedroom and did not want to change rooms.

However, some relatives informed us they had raised a concern or complaint about their family member's care and support and issues had been resolved. For example, one person told us, "I have made a complaint; staff were not hanging my clothes in the wardrobe. They sorted it out. They (staff) come once a month or every other month to see if I am happy with things." One relative said, "I speak my mind, if something wasn't right, I would tell them. I've no complaints, they are pretty good."

The registered manager showed us the 'compliments, concerns and complaints' folder. Since our last inspection, we saw 16 complaints were recorded and 270 compliments, which the registered manager confirmed was correct. Positive comments included 'thank you' cards for the 'care given to my family member' and 'thank you for the support given.' There was an overall log kept of the issues raised, however, these were not always used as an opportunity to learn and improve the service people received. The

registered manager told us most issues raised to them were individual so they were dealt with on that basis.

The registered manager told us the care co-coordinator sought regular feedback from people's relatives and the care co-coordinator said, "I try to speak with people's relatives here when they visit or phone them if they don't visit to see if everything is okay." The care co-coordinator told us they recorded the contact with relatives, however, they were unable to locate their records to show us. Relatives we spoke with could not recall any specific call seeking feedback on the quality of care. One relative told us they did not feel the registered manager was honest in their responses when they reported concerns.

The care co-ordinator told us that 'resident and relative' meetings took place and were an opportunity for people to be listened to and share their feedback. We asked how the care coordinator included people who were cared for in bed and unable to attend the meeting itself. They told us these people had not been included so far but as we had highlighted this, it was something they could do for the next meeting. Minutes of the meetings were kept, though no action plan was made to follow through on points raised. However, the care coordinator told us action was taken but not always recorded. For example, one relative had suggested, during the February 2017 meeting, that some butterfly stickers be placed on the glass doors of communal lounges so people did not accidently walk into them. The care co-ordinator told us some butterfly stickers had been purchased and placed on glass doors and further ones would be purchased for other glass doors in the home.

Inadequate

Is the service well-led?

Our findings

At our inspection in May 2016, we identified some improvements had been made to the overall governance of the home. However, we found further improvements were still needed in the effectiveness of the provider's systems and processes to audit the quality of the services provided. We rated this domain as 'requires improvement' and asked the provider to send us an action plan on how improvements would be made, which they did. However, at this inspection we found planned improvements had either not taken place or had not been sustained. We found systems and processes were not operated effectively to ensure good governance of the service and there was insufficient management oversight to check delegated duties were carried out effectively.

At our last inspection, we had found the provider was not displaying their inspection rating, and was not on their website information. The regulation for a provider to display their inspection rating says that providers must 'conspicuously' and 'legibly' display their CQC rating at their premises and on their website. The registered manager informed us they had not been aware of the regulation but would ensure the regulation was met. At this inspection, some improvement had been made and the rating was displayed on the provider's website. However, the poster on the wall in the entrance area of the home was not displayed conspicuously or legibly because it was obscured by a poster display of other information.

This was a breach of Regulation 20A of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014

During our inspection visit we found the systems in place for the provider and registered manager to assess, monitor and mitigate risks to people's health and safety, failed to identify issues that required improvement and where people may as a result be at increased risk. Planned improvements had not been implemented or sustained since our last inspection. For example, audits undertaken were not used to identify where improvements were needed and there was insufficient management oversight to check delegated duties were carried out effectively. For example, the environment audit completed in February 2017, by the care coordinator, listed a check be made on 'radiator covers secure,' the care coordinator had recorded 'no, none got any on' against this audit check. However, no action was taken about this by them or the registered manager, who had delegated the audit to the care coordinator.

The registered manager told us they completed an informal daily 'walk around check' of the home and addressed any unsafe or poor practices they saw. However, unsafe and poor care practices observed by us were unchallenged. For example, at our last inspection in May 2016 we identified the boiling water urn posed a risk of harm or injury to people because staff left the urn unattended in a communal area. We were told this practice would cease but we found that the urn was still being used and was unattended by staff.

The analysis audit undertaken of people falling failed to identify the actions needed to minimise the risks of reoccurrence of falls at the home. The audit also failed to identify inconsistencies in accident and incident reporting by staff. Audits undertaken of people's care records had not identified where these were not accurate or sufficiently detailed. For example, where there were gaps in nursing records about monitoring

people's health condition or weight. Checks on people's risk assessments had failed to identify their safety and falls risk assessments were not reviewed when needed.

The medication audit completed by the matron in January 2017 had not identified issues we found. For example, the audit records medicines stored in the designated fridge were 'properly labelled.' However, we found a pharmacy box of influenza vaccines that was not labelled. The matron informed us this was from Autumn 2016, though their audits did not record this or any action having being taken.

The medication audit tool used by the provider was not always effective because it did not prompt checks on all aspects of the safe management of medicines. We found that some people did not have additional information available to staff about their 'when required' medicines, however, the audit tool did not include any check on individual 'when required' medicines having protocol information available to staff.

Audits of staff employment files were not effective in identifying where there were gaps in records. The registered manager had not given consideration to risk assessments where a worker's previous criminal convictions were listed or when an ex-staff member returned to work at the home and new checks were not undertaken.

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

There was a management structure in place at the home, but staff were not always clear about the role and responsibilities of each person and our observations showed shifts were not always well led. One staff member told us, "There is the (registered) manager, then matron and then a deputy matron, then the nurses and also team leaders, senior carers and carers." Staff were unable to tell us the different responsibilities between a team leader, senior carer and care worker. When we asked one staff member about this, they said they "didn't know."

We asked staff whether they felt supported and how they would describe the culture of the home and received mixed feedback. Some care staff told us they felt things were positive and they were part of a 'good team.' Nursing staff also, overall, told us they felt supported and everything was 'good' at the home. However, a few staff commented that 'a lot of good staff who did things the right way', had left and felt support from the registered manager needed to improve. One staff member told us, "There is too much arguing between team leaders, nurses and the care co coordinator. I'm not sure what the registered manager does."

Some staff told us resources and equipment was often slow to be provided by the registered manager. Comments to us included there not being enough hoists and two staff members gave us examples of when they felt unsupported by the registered manager when they asked for equipment needed to keep people safe. Staff told us that the registered manager had been asked for more special slide sheets for people and the response was they were too expensive at £7.00 each.

We gave feedback about concerns we had identified to the registered manager on 23 March 2017. The registered manager and managing director sent us a plan of immediate actions they intended to take. Two inspectors returned, unannounced, on 4 April 2017 to check if immediate actions had been taken in response to concerns identified had been implemented by the registered manager to address issues we identified.

We found some actions had been taken. The registered manager informed us they had told staff that the

boiling water urn must not be left unattended and we saw, on our third inspection day, the tea trolley was not left unattended. The registered manager told us they had taken action to ensure staff that working at the home were of good character and further DBS checks had been requested to update staff employment records when needed. Staff had not yet received their contracts of employment as planned for on 1 April 2017, however, the registered manager told us these were being worked on and would be given to staff before the end of the week; 7 April 2017.

Training in first aid 'train the trainer' and other refresher training sessions had been booked for the care coordinator to undertake during April and May 2017. The registered manager told us the care coordinator would then train to refresh all staff first aid knowledge and a qualified first aider would be on every shift by the end of May 2017. The registered manager said further training was being sourced for other staff and this included dementia awareness for the activities staff member.

Some safety equipment had been ordered, which included special fire evacuation mats. Two communal lounge radiators had been covered so that risks to people's skin being damaged were minimised. The managing director told us further radiator covers were being purchased and these would be used to cover radiators, in parts of the home that did not have under floor heating. We were told this work would be completed by the end of April 2017.

During the third day of our inspection, the matron spent time ensuring people with special pressure relieving mattresses had their air flow pump on the correct setting for their body weight and recorded the setting on the person's individual pump and in their care plan.

The matron informed us they planned to update people's personal emergency evacuation plans and ensure everyone had one available in the file that would be made available to emergency services if needed; by the end of April 2017.

Following our feedback on 23 March 2017, a risk assessment had been completed for people that smoked cigarettes. However, this was not detailed and failed to take into account of the risks of harm that we had identified. The registered manager told us this would be re-written and equipment purchased, such as a fire retardant cloth and a pendant alarm, so that safety equipment was made available to people.

On the third day of our inspection, we identified some further concerns. We identified a care worker on an 'unpaid trial shift.' The registered manager had not undertaken any employment checks and no induction or training had been provided. We told the registered manager that this was an unsafe recruitment practice and they stated to us the practice would cease immediately.

We found the registered manager had not taken action to minimise risks to people from broken equipment. One electronic bath chair had its 'safety arm' missing; however there was no sign to inform staff not to use the bath, the bathroom was not locked and the electronic bath chair was still operational. This posed a risk to people falling from the bath chair if staff used it. The registered manager told us the 'safety arm' had been missing for 'quite a while' but had not yet ordered a new one, they added they did not feel this was a 'safety risk' because people tended not to have baths and if they did want one then other baths were available for people to use in the home. We asked the registered manager to unplug the electronic bath chair and put a sign to tell staff not to use it, which they did.

We found one hoist that had a broken wheel was 'parked' where the usual hoists in use, for people needing them for transfers, were located. The hoist, with the broken wheel, did not have a sign on telling staff not to use it. We also saw this hoist had been due a Lifting Operations and Lifting Equipment Regulation, (LOLER),

test in August 2016. The registered manager was unable to show us records of a LOLER test having been completed for this hoist, which meant the hoist was not safe to be used due to the lack of testing and also the broken wheel. The matron agreed that due to where the unsafe hoist was 'parked' there was a risk of staff using it. We asked a team leader to remove the hoist from the building, and it was locked in the boiler room with a further two hoists not in use.

One person that lived at the home had told us they were sometimes not hoisted as assessed because of that difficulty staff had in getting a hoist when needed. The registered manager had not arranged a date for when the three out of action hoists would be repaired and / or LOLER tested. We were concerned this left only two operating hoists for staff to use; one for each floor. On the second floor, the team leader told us over 15 people needed to use a hoist for all transfers. We asked the registered manager to contact their LOLER and hoist repair engineer and request an urgent visit, which they did and a visit was scheduled for the next day; 5 April 2017. Following our third inspection day, the registered manager informed us that as from 5 April 2017 there were five hoists available for staff to use.

The registered manager and managing director were reactive in their management in dealing with issues once they were identified as a concern by us. However, we found they were not pro-active in identifying issues before risks arose from them.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks of harm and injury to people were not always identified by the provider and when they were, actions to minimise those risks were not always in place or followed by staff. The provider's systems to deal with emergencies did not protect people from the risk of harm of injury.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not have a safe system of staff recruitment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider did not conspicuously and legibly display their CQC rating at Oldbury Grange.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's systems and processes to monitor the quality and safety of the service were not effective in identifying where improvement was needed. There was a lack of management leadership and oversight.

The enforcement action we took:

Warning Notice served on the registered manager / provider