Runwood Homes Limited

The Grange

Inspection report

69 Southend Road
Wickford
Essex
SS11 8DX

Tel: 01268766466
Website: www.runwoodhomes.co.uk

Date of inspection visit:
24 August 2021
25 August 2021

Date of publication:
28 October 2021

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
The Grange is a residential care home providing personal and nursing care for up to 43 people aged 65 and over. At the time of the inspection the service was supporting 40 people. The service has two floors that are split into four areas.

People's experience of using this service and what we found
This inspection found concerns about staffing levels and the management of the service. People and their relatives gave us a mixed response about the service.

People's risks had not been clearly identified and recorded. People were at risk of falling, harm from others and choking because staff were not given sufficient guidance to reduce the risk. This was particularly important because of the use of agency staff. Medicines were not always managed safely, and people did not always receive their medicines as prescribed. Safeguarding concerns had been reported and investigated however, actions and lessons learned had not been implemented to ensure the concerns were fully addressed. Staffing levels at the service were not adequate. The provider needs to ensure there are always enough staff available to support people.

Governance systems at the service were not robust and had not been effective in managing and mitigating risk. There was a poor culture at the service. Staff did not feel supported or listened to. Action plans to drive improvement at the service had not been updated and issues highlighted had not been actioned.

The provider sent an action plan immediately after the inspection to tell us how they were going to address the concerns highlighted at this inspection. We were concerned the providers oversight and governance had not identified and addressed these matters independently of an inspection.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
The last rating for this service was good (published 19 October 2018).

Why we inspected
The inspection was prompted in part due to concerns received around staffing levels and risks to people. A decision was made for us to inspect and examine those risks.

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

You can see what action we have asked the provider to take at the end of this full report. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to risks to people, staffing levels and governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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..

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

The Grange

Detailed findings

Background to this inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.
http://crmlive/epublicsector_oui_enu/images/oui_icons/cqc-expand-icon.png
Inspection team
The inspection was carried out by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

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

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key

information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with four people who used the service and ten relatives about their experience of the care provided. We spoke with eleven members of staff including the regional operations director, a manager, deputy manager, senior care workers and care workers. 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 reviewed a range of records. This included six people's care records and multiple medication records. We looked at eight staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found and review action plans sent to us by the regional operations director.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate . This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- Risks to people had not always been safely monitored and managed.
- We observed one person choking during their lunch time meal. The risk assessment in place recorded the person coughed during or after food and drink. Although the GP had been made aware, there was no swallowing assessment and no information was available to advise staff how to monitor or support the person to mitigate the risk of choking.
- Another care plan we viewed identified a person needed support with managing feelings of anxiety. Daily notes recorded there had been 33 incidents between May and August 2021 where the person had become agitated or physically and verbally aggressive to staff and other people living at the service. There was no guidance for staff on how to manage their behaviour or support the person when this happened. This put them and others at a continued risk of harm.
- One person had fallen five times between May and August 2021. We checked their risk assessment which identified they were at risk of falls, however there was no guidance for staff to follow on how to reduce the risk of falls.
- The service was regularly employing agency staff to provide care to people. The lack of care planning and risk assessments meant these staff did not have clear, up to date guidance available to support them when looking after people they did not know.
- Where people had equipment in place that could restrict their freedom, mental capacity assessments [MCA] had not been completed to establish their capacity to agree to being restricted for their safety, or if this was in their best interests.

Using medicines safely

- People were not always supported to take their medicines safely.
- Medicine administration records reviewed showed medicines were not always available, which meant people had missed taking their medicines for several days. Where medicines were not available, staff had not made enough attempts to obtain new supplies, which could place people at risk of harm because they were not receiving their medicines as prescribed.

Risks relating to the health, safety and welfare of people were not robustly managed. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment; Learning lessons when things go wrong

- There were not enough staff. Staffing levels were calculated using a tool to assess the needs of people using the service. However, we found the service consistently did not have enough staff working on each

shift. The current staffing levels, deployment of staff and the layout of the building meant staff were not always in communal areas to support people who were at risk of falls if left unsupervised. The service had recorded a number of unwitnessed falls in communal areas.

● We reviewed the staff rotas which showed the number of staff working on each shift was below the calculated number. This included the day of the inspection. Although the provider assured us they had increased the number of staff in August 2021 this was not recorded on the staff rota. This meant we could not be assured this increase had been actioned.

● Staff told us there were not enough staff working and they felt under pressure. One staff member said, "There aren't enough of us. Carers are making all the beds, making all the breakfasts as well as getting everyone up. We only get one and a half hours to do this," and "We are stressed with all the extra work. It is very difficult to get through the work." Another said, "On four occasions it's been just me and an agency staff member."

● The service was reliant on agency staff to make up for staff shortages, however staff told us this was not always helping. One staff member said, "This morning, only one person was up. Last night, two agency staff were put together, they hadn't got anyone up as they didn't know their needs." This put people at risk of harm as staff were not knowledgeable about their current care needs.

● People and relatives told us there were not enough staff. They said, "They seem short staffed and there's not always someone in attendance in the lounge," and, "There were only two staff on shift between 1-8pm for 42 residents. The two staff did not get a break all day and one staff member went on to work the night." Also, "I think it is safe but sometimes there's not enough staff on. You have to wait ages if you want a drink or anything."

● We reviewed staff files for permanent and agency staff working at the service. Three of the four permanent staff files we looked at had no record of an induction taking place when they commenced their role. Two of the three agency staff had also not received and induction.

● There were systems in place to learn lessons when things go wrong, however we were not assured these were being used effectively to prevent further risk. For example, there had been a high number of unwitnessed falls in July 2021 but there was no analysis or action plan to address this. Where assurances had been given by the provider regarding staffing levels after a number or complaints and safeguarding referrals, staffing levels continued to be short impacting on the care people received.

Effective arrangements were not in place to ensure the correct staffing levels were in place. This demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had been recruited safely , which included checking references and disclosure and barring service [DBS]. However, there were no recruitment or training records for one of the agency staff members we reviewed.

● The regional operations director told us they were addressing the staffing issues at the service. The manager told us they had booked agency staff member in advance and were reviewing staff deployment and workload.

Systems and processes to safeguard people from the risk of abuse;

● Staff knew how to recognise abuse and who they should report it to, including external agencies such as the local authority. One staff member said, "I'd remove the resident from harm, I'd go above the manager and raise a safeguarding if I needed to. I'd follow policy and procedure."

● Systems were in place to raise and investigate concerns. A Relative said, "[Relative] is safe. I was contacted by the safeguarding team as [relative] has had two falls."

Preventing and controlling infection

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.
- We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The responses we received from staff and people using the service were not always positive about the culture and leadership at the service. Comments included, "Morale is low," "The leadership is not good, the staff meeting is just about asking staff why they haven't done stuff." "I don't think the registered manager knows how to speak to people, they are not a people person." "I don't feel supported," and, "I wouldn't feel comfortable to whistle-blow, they [management] always find out who it was."
- We did receive some positive feedback from staff members about the registered manager. One staff member said, "[Name of registered manager] is brilliant. [Registered manager] is approachable and supportive. I know managers can be the bad guys, but in my eyes [registered manager] is not, they work over their hours to get things done". Another staff member said, "I get on well with [registered manager], they ask a lot, but you can take a break.
- There was poor provider and manager oversight of the service. Systems for monitoring the quality and safety or the service were not effective. For example, in July 2021, 15 falls, most of which were unwitnessed and happened in communal areas, had been recorded. There had been no analysis of the falls or connection made between falls and staffing levels. No action plans had been put in place to address the issues. There was no guidance in place to show how the service was going to mitigate further risks to people.
- The provider had in place a range of audit tools; however, the registered manager had not been completing all the audits as required. The regional operation director had completed the monthly compliance report and recorded care plan audits had not been completed for June and July 2021. The report also highlighted issues with care plans such as incomplete risk assessments, missing mental capacity assessments and fluid charts not meeting targets. At the time of the inspection on 24 August 2021, there was no evidence any of these actions had been completed.
- We reviewed a quality assurance review, commissioned by the provider, and the home development plan. The home development plan had not been reviewed since May 2021and the quality assurance report showed most of the issues highlighted had not been actioned. There was no up to date action plan in place to show how the provider was planning to improve the service it provided to people.

Effective processes were not in place to monitor the safety and quality of the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● After the inspection we were told there had been positive meetings with the local authority and staff had been given the opportunity to speak anonymously with the providers Human Resources department.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Staff told us they received supervisions; however, they did not feel these were of value. One staff member said, "Supervisions are not useful, you can put what you like, I don't think they [management] read it." We reviewed supervision records and saw they were poorly completed. Where a member of staff had raised the same concern at two supervisions, no actions were documented to address the concern.

● The service had engaged with staff, people using the service and relatives. Issues raised had been addressed in action plans, however we could not be assured these were being effectively implemented due to the concerns found at the inspection.

● We received mixed feedback about communication. One relative said, "Communication is good, I always get a call if [relative] is unwell," Another said, "Communication is airy fairy, you always have to ask."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● Records we reviewed demonstrated the registered manager understood their responsibility to be open and honest when things went wrong. However, complaints we reviewed about concerns with staffing levels had only been addressed by the provider after concerns were raised with the local authority and the Care Quality Commission who contacted the provider to gain assurances.

Working in partnership with others

● The service worked in partnership with other health care professionals such as District Nurses and GP's as well as the local authority.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Effective arrangements were not in place to ensure the correct staffing levels were in place.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk relating to the health, safety and welfare of people were not robustly managed.

The enforcement action we took:

We have issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective processes were not in place to monitor the safety and quality of the service.

The enforcement action we took:

We have issued a warning notice.