Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Rastrick Grange

Close Lea Avenue, Brighouse, HD6 3DE

Tel: 01484723596

Date of Inspection: 16 January 2014

Date of Publication: March 2014

We inspected the following standards as part of a routine inspection. This is what we found:

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Staffing	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	Orchard Care Homes.Com (2) Limited
Registered Manager	Mrs. Joanne Louise Davy
Overview of the service	Rastrick Grange is a purpose built home. It offers residential care for 39 older people. The accommodation is arranged over three floors. All of the bedrooms are single and have en-suite toilets and showers. There are lounges and dining rooms on each floor. There is a garden area at the side of the building that can be used in fine weather and a car park to the front of the building.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

	Page
Summary of this inspection:	
Why we carried out this inspection	4
How we carried out this inspection	4
What people told us and what we found	4
More information about the provider	5
Our judgements for each standard inspected:	
Consent to care and treatment	6
Care and welfare of people who use services	7
Staffing	8
Assessing and monitoring the quality of service provision	10
About CQC Inspections	12
How we define our judgements	13
Glossary of terms we use in this report	15
Contact us	17

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 16 January 2014, observed how people were being cared for and talked with people who use the service. We talked with staff.

We reviewed quality assurance information.

What people told us and what we found

When we visited the home in June 2013 we spoke with one person's relative who told us they were not happy with the care their relative received. We saw there were no meaningful activities taking place for the people who lived at the home. Staff we spoke with told us they were worried about the number of staff on duty, as they felt people's needs were not being met despite staff doing their best.

We looked at the care records of four people and saw that three of the records contained consent documents which had been signed by the person's relative. We were unable to find the reason for this documented within the care record. We were also unable to find evidence of the home carrying out assessments of people's mental capacity. This was in relation to people making decisions about the care they received at the home. There was no evidence of any learning from incidents and incidents were not investigated. This meant appropriate changes that would reduce the risk of incidents recurring were not being made.

We said that improvements were needed.

We returned on this inspection to check whether improvements had been made.

We looked at the care records of three people and found there were now documents in place for the purpose of obtaining consent from people. We also found that, where people were not able to give consent the home were completing assessments of people's mental capacity.

We saw that numbers of care staff on duty had increased by 84 hours per week, and a staff member had been employed for the purposes of arranging and providing activities.

We spoke with the manager who told us that learning from incidents was now taking place.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

Reasons for our judgement

When we visited the home in June 2013 we looked at the care records of four people. We were told by staff that the individuals concerned experienced fluctuations in their mental capacity. This meant they were able to make some decisions but not others. We found that the home did not have arrangements in place for assessing people's mental capacity in relation to the care they were receiving at the home.

We said that improvements were needed.

We returned on this inspection to check whether improvements had been made.

We looked at the care records of three people and found they all contained documents regarding consent. These documents had not been signed by the individuals concerned as they were unable to give consent to the care they received at the home. We saw assessments of their mental capacity had been carried out and where appropriate, relatives and staff at the home had held a best interest meeting. This process ensured that the care the person received at the home was in their best interests.

We saw care plans were in place for each person which stated staff would act in their best interests with regard to personal care, medication, mobility, diet and nutrition and third party treatment. The care plans were reviewed regularly on a monthly basis. This showed that people's changing care needs were accounted for.

We looked at the mandatory training records for staff and saw they had all attended mental capacity and deprivation of liberty training. We also saw that senior staff who worked at the home had further training booked for February 2014.

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

When we visited the home in June 2013 we spoke with one person's relative who told us they were not happy with the care their relative received. We found the documentation regarding people's nutrition, weights and observations carried out to prevent falls was not up to date. We saw areas of the home which were used for storage were cluttered and untidy. We also saw that a set of weighing scales were faulty and had not been repaired. This meant people who required their weight to be monitored on a regular basis were unable to have this done. The home had some signage in place which allowed for photographs to be kept on people's bedroom doors. We saw a large number of these were not in place. The manager told us people who lived at the home had pulled them off.

We said that improvements were needed.

We returned on this inspection to check whether improvements had been made.

We looked around the home and found two bathroom's had been converted into storage areas. This meant the home had more space to store equipment and people's belongings. We saw the signage in place at the home had been replaced, and people's bedroom doors had photographs and personal items in place. This showed the home respected people as individuals.

We looked at the care records of three people which included daily documentation of observations carried out by staff. This included records of what people were eating and drinking, pressure care and falls monitoring. We were told by the manager that care records had been reviewed and updated for all of the people living at the home. We saw people's care plans had been redeveloped with the involvement of people and their relatives. This showed people who lived at the home had been consulted about the care and treatment provided for them.

We observed lunch being served to people in two areas of the home. We saw staff appeared more organised and people living at the home were given sufficient time and support with their meals if they required it.

Staffing ✓ Met this standard

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

When we visited the home in June 2013 we saw staff appeared very busy and had little time to interact with the people they were providing care for. We spoke with care staff about how they met people's care needs. They told us there were not enough staff on duty to meet the dependency needs of the people who lived at the home. We asked if people who lived at the home had access to activities. We were told that one activity worker provided activities across two homes. This meant one member of staff who worked 30 hours per week provided activities for 79 people. We looked at records of accidents and incidents within the home and saw there had been a high number of falls between February 2013 and June 2013. Staff we spoke with told us they felt people living at the home were unsafe. They told us there were not enough staff to support people when they were trying to walk around the units.

We said that improvements were needed.

We returned on this inspection to check whether improvements had been made.

We spoke with the manager and the care manager about changes to staffing since our last inspection. They told us they had increased the number of care hours provided by 84 hours per week. This meant an extra member of staff was on duty between 10.30am and 10.30pm every day. This staff member acted as a 'floating' member of staff and worked between the three floors of the home. This meant each of the three floors of the home had two staff members on duty throughout the day. We spoke with two staff and one of them told us this had made a massive difference. The other staff member told us it had made no impact as the 'floater' always ended up working on the top floor. We discussed this with the manager who told us that recently the top floor of the home had appeared to be busier. This had resulted in the extra staff member spending a lot of their time there supporting staff. The provider may find it useful to note that if the top floor of the home continued to be busy, it may require an extra dedicated member of staff on a permanent basis

The manager told us there had also been some changes regarding the employment of a part time administrator to the home. We were told this had made a big difference to the organisation of the administrative tasks within the home. For example senior staff were now able to spend more time supporting care staff across the three floors of the home.

We saw the home had a member of staff in place for arranging and providing activities. They provided activities to the home for 20 hours per week and the adjoining home for 20 hours per week. We saw there was a structured activity programme in place for people which included one to one time with people. This showed the service had improved in meeting the social needs of people who lived at the home.

Assessing and monitoring the quality of service provision ✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

Reasons for our judgement

When we visited the home in June 2013 we looked at how the service had learned from accidents and incidents which had occurred in the home. We saw that appropriate recording of accidents and incidents were taking place, however there was no evidence to show they had been investigated. We saw a large number of documents where it asked for the name of the person who investigated the accident or incident it was left blank. Also where the document required any action taken to prevent recurrences to be recorded we saw this was also blank. We saw there had been no action plan had been developed following a high number of falls recorded in the home since February 2013. This meant incidents that resulted in harm, or had the potential to result in harm, were not being analysed and acted upon. This meant appropriate changes to people's care and treatment were not being made.

We said that improvements were needed.

We returned on this inspection to check whether improvements had been made.

We spoke to the manager about changes they had made to how the service investigated accidents and incidents occurring within the home. They told us there was now a system in place where a designated person carried out an investigation of the incident and provided a written summary. This was kept with the incident record. Any actions required were the responsibility of the staff member carrying out the investigation.

The manager also told us they were gathering information on a monthly basis to identify trends and themes of incidents. This included areas of the home where most incidents occurred, staff members on duty at the time of the incident and the number of incidents per person living at the home.

Further analysis of incidents was also carried out for those people who had two or more accidents or incidents per month.

We looked at the home's records of accidents and incidents and saw actions put in place

were signed off by staff as being carried out. For example where one person had two or more falls in November 2013 they were referred to the falls prevention team. This had resulted in a piece of equipment being put in place which would alert staff if the person left the area they were in. Another person had also fallen three times in December 2013, they were placed on close observation for a period of time. They also received a visit from their GP which confirmed they were suffering from an infection.

This showed that learning from incidents took place and appropriate changes were being implemented.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk

Copyright Copyright © (2011) Care Quality Commission (CQC). This publication may be reproduced in whole or in part, free of charge, in any format or medium provided that it is not used for commercial gain. This consent is subject to the material being reproduced accurately and on proviso that it is not used in a derogatory manner or misleading context. The material should be acknowledged as CQC copyright, with the title and date of publication of the document specified.