Inspection Report

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

Castle Grange

Ings Lane, Newsome, Huddersfield, HD4 6LT

Tel: 01484223439

Date of Inspection: 06 August 2013

Date of Publication: October 2013

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

Respecting and involving people who use services	✖ Action needed
Consent to care and treatment	✖ Action needed
Care and welfare of people who use services	✖ Action needed
Safeguarding people who use services from abuse	✓ Met this standard
Staffing	✖ Action needed
Assessing and monitoring the quality of service provision	✓ Met this standard
Records	✖ Action needed

Details about this location

Registered Provider	Kirklees Metropolitan Council
Registered Manager	Ms. Sarah Nunns
Overview of the service	The location is registered to provide personal care for up to 40 people.
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'.

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 6 August 2013, observed how people were being cared for and talked with people who use the service. We talked with staff and reviewed information sent to us by commissioners of services.

What people told us and what we found

When we visited the home we spoke one person who told us 'People here are very nice, I like my room'. Another person told us they looked forward to weekly visits from the hairdresser. We observed there were issues with the home having no staff available to provide activities for people who lived at the home. We also observed that staff were respectful of people when they were talking with them. However, we observed practices that showed very little regard for people.

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

What we have told the provider to do

We have asked the provider to send us a report by 23 October 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

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

Respecting and involving people who use services ✖ Action needed

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was not meeting this standard.

People were not supported in promoting their independence and involvement.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

People's privacy, dignity and independence were not respected.

We observed that staff were respectful of people when they were talking with them. However, we observed practices that showed very little regard for people. These were some examples:

Some people did not look well cared for. We saw people with food stains on their clothing, dirty nails, unwashed and uncared for hair and two people smelled strongly of urine. We saw three people wearing skirts with no stockings on, one person was wearing rolled down socks leaving their legs bare.

We looked in people's bedrooms and saw in one person's room there was a soiled incontinence pad and items of dirty clothing in a pile on the floor of their ensuite shower room. A used wipe had been left in the sink. In another room we looked at we saw the shower appeared dry and unused.

We saw that people were assisted to be seated for breakfast in the dining room. We saw one person was sat for two hours in the same chair and was not asked if they wanted to use the toilet. We observed that one person was given a slice of toast and a drink, they were not asked what they would like. This person did not eat the toast and we saw another person take the toast off them.

People were not given assistance with their breakfast and two people had fallen asleep at the table after their breakfast had been taken away from them uneaten. One person was offered a more comfortable chair in the lounge area when staff noticed they were asleep.

We saw that one person had been led through to the dining room by a staff member. The person came over to speak with us and we saw the person had been incontinent. We

spoke with the staff member who told us they had not observed a problem. We had to speak with them again regarding our concerns before they assisted the person to the toilet.

At lunchtime on one of the suite's there were no condiments or sauces available and on another suite we saw that only one table out of three had a cloth on it. People were offered disposable plastic aprons to protect their clothing. We saw that people were offered choices of meal verbally instead of staff showing them what was available. This led to some people being confused and they ended up having a bit of everything on their plate. Some people struggled with the meat on their plate and had to have assistance from the staff to cut it up. We also saw two people eating their meal with their fingers and this went unnoticed by staff.

We saw one person being hoisted in one of the lounge areas. The person had a skirt on and the staff did not notice that this had ridden up leaving their legs bare. This meant the person's dignity was not maintained.

Consent to care and treatment ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

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

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Before people received any care or treatment they were not asked for their consent and the provider did not act in accordance with their wishes.

We looked in four people's care record's and found in one person's record's there was a a consent document in place which was signed by them to show they gave their consent to photographs or interviews. There was also document in place which enabled the individual concerned or their relatives to sign to say they were in agreement with the care plan in place for them. We saw this document was not signed or dated.

We saw in another person's record's their care plans, risk assessments and advanced care plan had been completed in consultation with the person, their family and staff from the home. This was dated 25 May 2011 and stated it was to be reviewed every six months. We were unable to see any evidence of the review's taking place. We also saw that this person had consented to their photograph being taken.

In two other care record's we looked at we were unable to find any evidence of how both people had consented to the care they were receiving at the home. In one of the records we saw the persons photograph on the front of an information sheet within their file however, we were unable to find evidence they had consented for their photograph to be taken or used. In the other care record we saw the person's relative had signed to give their consent for photographs to be taken. There was no evidence within the record to say why the individual concerned was unable to give their consent.

When we looked around the home we saw people's bedrooms were locked. Staff told us that this was to stop other people who lived at the home wandering in to the rooms. We were told that people had signed to agree to this. We looked in four people's care record's we found that only three of the record's contained documents regarding this.

In one record the document was dated 5 May 2012 with no evidence of this being reviewed. In another record the document was signed by the individual concerned but did

not identify their decision to have their room locked or to have a key. In another record we saw the person's relative had signed to say the person was to have their door locked however, we were unable to see a reason as to why the relative had signed and not the person themself.

We discussed with the manager the arrangements the home had in place for the purposes of assessing people's mental capacity in relation to making decisions about the care they received. We were told that the home did not have any procedures in place for this at the time of our inspection. This meant that people who did not have the mental capacity to consent to their care and treatment, were not supported them by the home to have the involvement of their significant others in decisions about their care.

Care and welfare of people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Care and treatment was not planned and delivered in a way that was intended to ensure people's safety and welfare.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

People's needs were not adequately assessed and care and treatment was not planned and delivered in line with their individual care plan.

We looked the care records of four people who lived at the home and found there was no evidence to show the individuals concerned were being offered regular activities. In one person's records we saw it required staff to document activities which the person had taken part in this was blank. In another person's record their involvement in activities was recorded as 'chatting with others'.

We were told by the manager of the home that they did not employ a staff member to provide activities and care staff were to carry this out when they were available. We observed that staff who worked at the home were busy meeting people's basic care needs and were unable to offer regular, planned activities to people who lived at the home. We also saw there was no timetable in place to show if any activities were planned for people who lived at the home. We looked at the resources available for staff to provide activities and saw there was very little available. For example, nail care was regarded as an activity within the home however we felt this should be part of routine care rather than identified as an activity. Staff told us that there were not enough manicure kits within the home to enable this be facilitated regularly. The delivery of care, treatment and support should maintain people's welfare by taking account of all their needs. This should include consideration of people's mental, social, and emotional needs, including daytime activities.

In one of the care records we looked at we saw the person required observations to be carried out of them due to some of the behaviours they displayed. We sat with the person in the lounge area for 45 minutes and saw that this person was not observed by staff. We also saw in this person's care records that they enjoyed a daily shower however, it was documented in their daily reports for the last four days they had only had one shower. This person also had an oral health assessment completed for them which stated they wore dentures. We were unable to see any evidence of them visiting a dentist in the 12 months prior to our inspection.

In another care record we looked at we saw the person had been assessed as being at high risk of falls. We observed the care of this person throughout our inspection and saw they received very little support from staff despite walking around the top floor of the home throughout the morning. This person did appear unsteady at times but also was observed taking items from other people who lived at the home such as food and personal belongings. We saw there was no care plan in place to provide staff with clear guidance on how to manage this person's risk of falls.

Safeguarding people who use services from abuse ✓ Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

We spoke with the manager of the home who told us that all but one staff member had completed training in safeguarding adults in the last 12 months. We spoke with two staff on duty during our inspection and they were both able to describe clearly what action they would take in the event they had concerns that abuse was taking place. They told us they would report their concerns to the person in charge that day and also ensure there was clear documentation to support their concerns. This was in line with the procedure in place at the home. However, the provider may wish to note that both staff members were not aware that they could report any concerns directly to the local authority safeguarding adults team.

Staffing ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

There were not enough qualified, skilled and experienced staff to meet people's needs.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We spoke with the manager of the home who told us there had been some changes to how staff were deployed within the home. This was due to the fact that the home had recently stopped taking admissions and was not using one of their ten bedded suites. The manager told us this meant there were more staff available to meet the needs of people who lived at the home at the time of our inspection. We observed during the morning of our inspection that people were receiving support with personal care from staff and were then taken to the dining area. They were given their breakfast but with little interaction or support to eat from staff. We saw that staff were busy and were rushing off to assist other people to get up leaving others in the dining area until lunchtime. This meant that people were left for long periods of time with no support from staff.

We saw throughout the morning after breakfast that people were reseated in the lounge area with little interaction from staff and several of them fell asleep. Staff appeared very busy and at this point and domestic staff who had been assisting with getting people seated for breakfast were going back to their domestic tasks. At lunch time on one of the suites we saw that a member of staff who had been completing paperwork in the office throughout the morning came out to assist people with their lunch. This enabled other staff members to assist people on a one to one basis.

On another suite we saw that due to staff not getting additional support, people who lived at the home were being seated for lunch and it took 15 minutes for staff to serve lunch. This meant that some people had been seated for almost 25 minutes before their meal was served. We were also concerned at the limited amount of time that staff appeared to be available in the communal areas of the home to offer support to people. When we looked in one persons care records we saw they had had 15 falls since the beginning of April 2013. We found that all of these were unwitnessed by staff and 12 of these were in communal areas. This meant there were not enough staff to maintain people's safety.

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 to regularly assess and monitor the quality of service that people receive.

Reasons for our judgement

We saw that a recent CQC inspection at another home under the same provider had impacted on the way the manager now completed audits and checks within the home. The manager had a series of checks in place which were intended to be carried out on a monthly, 3 monthly and 6 monthly basis. We saw these checks covered areas of health and safety, training, safeguarding, fire, defaults, accidents, staff files and infection control. When we looked at the dates of completion of the checks we saw that for the monthly and 3 monthly checks these had been completed. However, there was no file in place for the manager's 6 monthly checks. We saw that an annual health and safety audit had been completed for 2013 and covered areas such as electricity, building safety, hygiene, housekeeping and waste. We looked at the areas which described contingency plans and found these were all up to date and described clearly the action staff were to take in the event of an emergency.

We looked at the results of a family and carer's questionnaire which had been carried out in June 2013. These are some of the comments people made:

'Maybe the home could increase stimulation for people to avoid boredom'. 'As a family we like to be made aware of when our relative's wellbeing'. 'What if any activities take place, when, where and description of the same'. 'My relative seems happy and comfortable'. 'Family have picked up on health issues rather than staff'. 'Name tags for staff will help residents and relatives'.

We were not shown any action plan that the service had developed in response to any of these comments.

Records ✖ Action needed

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was not meeting this standard.

People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

People's personal records including medical records were not accurate and fit for purpose.

We looked at four people's care records which contained assessments of people's needs, risk assessments, care plans and daily report documents. We found in all four records that staff were recording their care of people inconsistently and not in the specified area of the care record. For example, one person's daily report contained no information relating to their food and fluid intake and had a line through this section however, we saw that a separate document had been completed for the person and was located within the risk assessment section of the record. This meant the care which people received was not recorded accurately or in a way that could be followed easily.

We found within all four care records that several areas of the assessment documents were not completed. We also found that parts of the documents which were intended to give staff guidance on the level of support the individual concerned required were left blank. For example in one person's records we saw in their personal history profile that a section on 'how do I like to do things' the following sections on special routines, time to get up and time to go to bed at night were also left blank. This meant that records did not provide staff with clear guidance on how to meet people's needs.

We found in another person's records their nutritional chart was not completed and their file also contained incomplete charts regarding the daily amounts the person was eating and drinking. Within the same document in a section to identify the kind of diet the person required the options were 'normal/soft/liquidised/diabetic/other' we found this was also not completed. In a section to identify the level of assistance the person required with eating and drinking we found this section was not completed. This meant that information regarding the person's needs was not available for staff who were providing support.

We looked in another person's care record who had recently experienced weight loss and saw they required a high calorie diet. It was also written in their dietary risk assessment for staff to offer snacks and Complan to the person throughout the day. However, when we

looked at the recordings by staff on the person's daily diet sheets we saw that for three days there were no recordings made of snacks being offered to the person. On another day the were no recordings for any food or fluid intake between breakfast and supper. The following day there was nothing recorded for this person after lunch. This meant it was not possible to establish if the person's food and fluid intake was adequate.

We looked in one person's en-suite bathroom and saw they had a cream prescribed for a skin condition. We looked in the care records for this person and saw there was no care plan in place to give staff clear guidance on how often or where to apply the cream. We also looked at the daily report records for this person and saw there was no documentation to say that staff had applied the cream. This meant that the person's care plan did not provide staff with clear guidance on how to deliver treatment which had been prescribed.

In another person's care record we saw it was documented that the person had received 'full assistance' from staff but it was not clear what they'd received assistance with. In this person's care record their care plans had been formulated in May 2011 and stated they were to be reviewed every six months. We were unable to find clear evidence of the reviews taking place.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010** **Respecting and involving people who use services**
	How the regulation was not being met: People's privacy, dignity and independence were not respected.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010** **Consent to care and treatment**
	How the regulation was not being met: Where people did not have the capacity to consent, the provider did not act in accordance with legal requirements.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: Care and treatment was not planned and delivered in a way that was intended to ensure people's safety and welfare.
Regulated activity	Regulation

This section is primarily information for the provider

Accommodation for persons who require nursing or personal care	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met: There were not enough qualified, skilled and experienced staff to meet people's needs.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 23 October 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

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

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