Orchard Care Homes.Com (2) Limited

Rastrick Grange

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Rastrick Grange 3 February 2016 and the visit was unannounced. Our last inspection took place on 16 January 2014 and, at that time, we found the regulations we looked at were being met.

Rastrick Grange is a purpose built home. It offers residential care for 39 people living with dementia. 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.

At the time of this inspection there were 37 people using the service.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There were not always enough staff on duty to care for people safely or to make sure their needs were met in a timely way. People told us they liked the staff and found them kind and caring. We witnessed some warm and good humoured relationships between people using the service and staff.

People told us they felt safe in the home. Staff had a good understanding of how to control risks to people's health, safety and welfare.

Staff told us they felt the quality and variety of meals could be improved. We found people's choice of meal was very limited, as people living with dementia were being expected to choose their meals a day in advance rather than being able to see the meals to make an informed choice. The mealtime experience for people varied depending on which floor or which staff were assisting them.

We found people had access to healthcare services and these were accessed in a timely way to make sure people's healthcare needs were met. Safe systems were in place to manage medicines; however, people did not always receive their medicines at the correct times.

We found the service was meeting the legal requirements relating to the Deprivation of Liberty Safeguards (DoLS).

Visitors told us they were made to feel welcome and if they had any concerns they would speak to the registered manager or another member of staff.

We found some of the audits which were in place were effective. However, there was a lack of environmental audits or use of a tool to calculate staffing levels. This meant the service was not monitoring its quality in

these areas and responding where improvements were needed. Relatives told us they did not always feel their views were being listened to.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and you can see what action we 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?

Requires Improvement

The service was not always safe.

Staff were recruited safely but there were not always enough staff on duty to meet people's needs in a timely way.

Staff understood how to identify and manage risks to people's health and safety and people told us they felt safe in the home.

Overall, medicines were managed safely but they were not always given at the correct times.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were inducted, trained and supported to ensure they had the skills and knowledge to meet people's needs.

The quality and variety of meals was variable and people were not being given a real choice of meals.

The legal requirements relating to Deprivation of Liberty Safeguards (DoLS) were being met. People were supported to access health care services to meet their individual needs.

Is the service caring?

Good

The service was caring.

Staff were kind and caring and mostly treated people with respect.

Visitors were made to feel welcome and said staff were friendly.

Is the service responsive?

Good

The service was responsive.

People's care records provided information which showed the care and support each individual required.

There were some activities on offer to keep people occupied.

There was a complaints procedure in place and people knew how to raise any concerns.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a registered manager who provided leadership and direction to the staff team.

Quality assurance systems were in place but these needed to improve to ensure they were effective in identifying the improvements which needed to be made.

Rastrick Grange

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.

This inspection took place on 3 February 2016 and was unannounced.

The inspection team consisted of two inspectors.

Before the inspection we reviewed the information we held about the service. This included notifications from the provider and speaking with the local authority contracts and safeguarding teams. We also received a completed a Provider Information Return (PIR). This 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.

We spent time observing care in the lounges and dining rooms and used the Short Observational Framework for Inspections (SOFI), which is a way of observing care to help us understand the experience of people using the service who could not express their views to us. We looked around some areas of the building including bedrooms, bathrooms and communal areas. We also spent time looking at records, which included ten people's care records, six staff recruitment records and records relating to the management of the service.

On the day of our inspection we spoke with eight people who lived at Rastrick Grange, five relatives, five care workers working the day shift, three night care workers, the deputy manager, the registered manager, care manager, deputy manager and two social workers.

Requires Improvement

Is the service safe?

Our findings

We spoke with four night care workers who told us the night staffing levels had been increased within the last week, following our inspection of the adjacent home Rastrick Hall. They told us with five members of staff, working across the three floors they were able to meet people's needs in a timely way.

We saw during the day, a deputy manager was on duty and two members of care staff were allocated to each floor with a senior care assistant 'floating' between the three floors offering assistance where required. On the day of our inspection there was also a care worker who was supernumerary as they were completing their induction training.

We saw at times staffing levels were not adequate to ensure people's safety. For example, during the afternoon we took the care manager to the first floor lounge where no care staff were present. One of the people using the service had their arm hanging over the side of the chair and looked very uncomfortable. Another person using the service went over to them and tried to reposition them in the chair. The care manager intervened, but accepted this would have gone unnoticed as no one was supervising the lounge area.

Staff we spoke with told us the lounge areas were not always supervised as both carers on their allocated floor could be assisting people in their bedrooms or to the toilet. We also noted there was only one hoist for the whole home. Staff told us there were two people on both the ground and first floors who required this equipment to meet their moving and handling needs. This led to staff time being wasted in both areas waiting for the hoist and having to go to another floor to collect the equipment. We saw on one occasion a person waiting for over 10 minutes for the hoist to be made available.

We saw one person was not wearing any slippers. Staff told us this was because another person on that floor went in and out of other people's bedrooms and removed various items. They told us there were not enough staff on duty to check the whereabouts of this person at all times. We concluded there were not enough staff on duty during the day to ensure people's safety.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff recruitment processes were in place and ensured staff were safe and suitable to work at the home. A new member of staff told us that they had not been allowed to start work until the provider had received checks regarding their suitability to care for vulnerable people. This included references from previous employers and clearance from the Disclosure and Barring Scheme (DBS). We looked at this person's recruitment records which confirmed the principles of good practice were followed to help keep people safe. We looked at a further five files which confirmed robust procedures were always followed.

People said they felt safe at the service. One person said, "I feel safe and I am very well looked after." Another person told us, "It's lovely here; I am safe and warm and all my needs are catered for".

Staff we spoke with told us they had received 'safeguarding adults from the risk of abuse' training and training records we saw confirmed this training had taken place. Staff were able to demonstrate a good understanding of safeguarding issues and were able to give examples of how they would identify abuse. They all told us they would not hesitate to report any concerns to the care manager or registered manager. This meant staff understood how to keep people safe.
The registered manager had sent us notifications appropriately about safeguarding incidents which had occurred in the home.

Risks to people's health and safety were understood and appropriately controlled by the service. Where staff had identified any risks to individuals they had taken action to mitigate those risks. For example, some people had pressure mats in their bedrooms. These mats were connected to the emergency call system giving staff early warning if the individual was getting up. We asked staff why these were in place and they told us if people were at risk of falling these mats were used to try and reduce that risk. We also saw pressure relieving cushions and mattresses were in use for people who had been identified as being at risk of developing pressure damage to their skin. The management of people's skin integrity was good as no one within the home had any pressure damage. We also saw where people had been assessed as being nutritionally at risk action had been taken to reduce this risk, for example, food supplements had been obtained from the GP or the dietician had been involved for advice.

We saw a range of checks were undertaken on the premises and equipment to help keep people safe. These included checks on the fire detection equipment, gas installations, hot water and lifting equipment. A system was in place for staff to report any defects to ensure they were repaired. We looked around the home and saw all of the radiators were covered to protect vulnerable people from the risk of injury. We saw fire-fighting equipment was available and emergency lighting was in place. During our inspection we found all fire escapes were kept clear of obstructions. We saw upstairs windows all had opening restrictors in place and floor coverings were well fitted posing no trip hazards.

We saw the communal areas and corridors had been greatly improved by recent refurbishment, however, some of the bedrooms were in need of redecoration and some refurbishment to bring them up to standard.

Medicines were administered to people by trained care staff. We were told people were assessed as to their capability to self-medicate. We saw people's care plans demonstrated either they lacked capacity or had chosen not to self-medicate. The documentation in the form of medicine administration records (MAR), administration protocols and stock control were all electronic. Staff guided us through the process which we found largely to be robust. The system demonstrated people had received their medicines. However, our observations of the morning medicine round showed the pharmacists advice on safe administration of medicines was not being followed. We saw one person was prescribed Lansoprazole 30mgs daily and Perindopril 4mgs. We witnessed the medicines being administered directly after breakfast yet the written instructions stated it should be given 30 to 60 minutes before food. Likewise we saw a person was prescribed Quetiapine 50mgs. We witnessed the medicine being administered after breakfast, yet the written instructions said it should be taken on an empty stomach. We conducted an audit of boxed medicines and found on one occasion there was an imbalance in stock levels. Scrutiny of the system showed this to be an accounting error rather than people not being administered their medicines.

We found medicine trolleys and storage cupboards were secure, clean and well organised. We saw the drug refrigerator and controlled drugs cupboard provided appropriate storage. Allergies or know drug reactions were clearly annotated on each person's electronic MAR.

Some prescription medicines contain drugs controlled under the misuse of drugs legislation. These

medicines are called controlled medicines. We inspected the contents of the controlled medicine's cabinet and controlled medicines register and found all drugs accurately recorded and accounted for.

We noted the date of opening was recorded on all liquids, creams and eye drops that were being used and found the dates were within permitted timescales. Creams and ointments were prescribed and dispensed on an individual basis. The application of creams was recorded on a separate paper sheet.

We saw the drug refrigerator and controlled drugs cupboard provided appropriate storage for the amount and type of items in use. The medicine trolley was secured to the wall when not in use. Drug refrigerator and storage temperatures were checked and recorded daily to ensure that medicines were being stored at the required temperatures.

Whilst no person was receiving their medicines by covert means the registered manager had a good understanding of the legal framework which applied, should medicines need to be given covertly.

We spoke with the registered manager and senior care staff about contingency plans in case of failure of the electronic system. We saw paper MAR sheets existed and could quickly be brought into use. However, the deputy manager did not know if the system could be inputted with manual records at a later date. Furthermore whilst the system gave staff some level of guidance on the administration of 'as necessary' (PRN) medicines it did not record the safe period of time between each administration. The deputy manager said they would discuss our observations with the system supplier.

We recommend the service review their procedures to reflect the National Institute for Health and Care Excellence (NICE) guidance for managing medicines in care homes.

Requires Improvement

Is the service effective?

Our findings

New staff completed an induction process and received training and support to develop their skills. Additional and refresher training was provided for established staff as needed. Newly appointed care staff went through an induction period which included shadowing an experienced member of staff. On the day of our inspection we witnessed this taking place to significant effect. We saw the newly appointed member of staff demonstrated good caring skills and a good understanding of people's needs. All staff we spoke with and observed demonstrated they had the necessary knowledge and skills to meet the needs of the people using the service. They were able to describe people as individuals. Staff knew about people's likes, dislikes and preferences. However, on a very few occasions we saw staff using their understanding of people in a negative way such as making choices for people rather than asking. We saw a training programme which recorded the training staff had received or which was planned. Scrutiny of staff files provided certificated evidence of staff's training achievements which correlated with the training programme. Staff received regular supervision with the manager or a member of senior staff and also attended team meetings.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The manager told us 11 people were subject to an authorised DoLS with further authorisations awaiting consideration by the supervisory body.

Scrutiny of care plans showed one person with DoLS in place which was subject to three conditions. The authorisation had been received immediately prior to our visit but the conditions were being attended to and incorporated into the person's care plan.

Care plans showed decision specific mental capacity assessments were carried out and not solely because of people's illness, disability, age, appearance or behaviour. For example, we saw people were assessed to gauge their capacity to administer their own medicines. We also saw evidence of a person who had been judged to have capacity deciding not to take prescribed medicines on a regular basis. Whilst concerns had been shared with the person's GP those engaged in caring for the person were respecting the person's rights and upholding this important principle in the law.

We asked the registered manager about consenting procedures at the home and if necessary the involvement of families who were either attorney's with lasting powers of attorney or deputies appointed by

the Court of Protection. The registered manager showed us their records of such arrangements. We saw the registered manager had a robust system of both engaging with families and securing proof of attorneys and donors. We looked at people's care plans and saw attorneys had been engaged in care planning and had signed their approval to consent to such matters as winter 'flu jabs.

We asked the registered manager about restraint practices at the home. We saw the provider had a policy for staff to follow when potential restraint matters were being considered. For example, we saw when bed-rails were to be considered a procedure existed to ensure the use was for reasons of safety or to reduce anxiety rather than to control. The Commission was informed by formal notification of an occurrence in December 2015 when physical restraint was required as a last resort to protect someone from harm. Whilst the provider's policy describes the use of "minimal" physical restraint in certain circumstances we found no guidance for staff as to what actions they may take. The registered manager assured us they would review their procedures and ensure staff were suitably trained in acceptable restraint methods.

Some of the staff we spoke with told us they thought the quality of some of the meals was poor, for example meat being tough, and felt more variety could be offered.

We found whilst people were supported to have sufficient amounts to eat and drink to maintain a balanced diet, staff did not always communicate the full choice of options on offer. During lunch and dinner we heard staff speaking with people with advanced dementia asking for their choice of meal. We saw some people making no response and thereafter staff making the choice on their behalf. As a prompt for choice we did not see staff showing people what was available. In addition, people were not consulted in a meaningful way about their preferences. Many people at the home were living with dementia or other conditions affecting cognition or memory. People with known short-term memory loss were asked the day before what they would like to eat the following day. We judged this method of offering choice to be of limited benefit.

People's meal time experienced varied depending on which floor they took their meal. For example, on the middle floor at breakfast time there was only just enough porridge and none left to give anyone a second portion. No fruit juice was available and people were offered lemon or blackcurrant squash. There was only a cooked breakfast for one person, staff told us it was because they were the only person who had ordered a cooked breakfast the day before. Tables were not set with cutlery, crockery and only three serviettes were available, although there were eight people sitting at the dining tables and one person sitting in the lounge areas. We saw staff put bowls of porridge in front of people, who made no attempt to eat it, by the time staff returned to offer support and encouragement the porridge was cold.

At lunchtime, again on the second floor, seven people were seated at the dining tables at 12:10pm. The tables had not been set with cutlery serviettes, glasses or a full range of condiments. Some tables had salt and vinegar, whilst others had pepper and vinegar. The lunch trolley did not arrive until 12:35pm. This meant people had been sitting for 25 minutes waiting for their lunch. We saw one member of staff put three sandwiches on a saucer for one person. They took them to the table and then proceeded to rip the crusts of with their fingers before serving them. We saw one senior care worker sitting with three people at a table offering full support to one person with their meal whilst gently encouraging the other two people with their sandwiches and soup.

We spoke to the registered manager and care manager about our observations of the meal times and they were very disappointed as the 'meal time experience' for people was something they had been working on recently. They assured us they would continue to work on this so mealtimes would be a pleasant and social occasion for people.

Our tour of the building showed many aspects of a dementia friendly environment. Toilet and bathrooms doors used pictures and words of a size easily recognised. The home provided sufficient space between chairs to enable carers to help people with their needs. The ground floor conservatory benefitted from patio doors which gave access to a level outdoor space. We saw the colour and choice of flooring materials contrasted with the colour of walls and furniture. These measures helped people who may be trying to make sense of the world around them and as a result add quality to their lives. However, we also saw some negative aspects within the environment. The weekly activity planner on two floors was a week out of date and a large clock in a prominent position was stopped. The registered manager told us they would remedy these issues without delay.

People's healthcare needs were regularly monitored. Health care plans were detailed and recorded people's specific needs, such as diabetes. There was evidence of regular consultations with health care professionals where needed, such as dentists, GP's, opticians, community care staff and podiatrists. Concerns about people's health had been followed up and there was evidence of this in people's care plans. We saw where other health care professionals had been consulted their advice had been taken to good effect. For example, one person had a recent history of increased incidents of falling. We saw they had been referred to the community falls assessment team, who had referred the person on for a review of their medicines. We saw one medicine had been reduced and since there had been no further falls.

Good

Is the service caring?

Our findings

People living at Rastrick Grange spoke positively of the care they received and the relationships they have with staff. Comments included, "Yes it's lovely here," "They care for me so well," and "Most things are fine." Relatives also spoke positively about staff and the standard of care their family member received. One relative said, "I am totally happy with the care but I wish they [staff] didn't have to do so much paperwork." Another relative told us, "I come every day and the staff are very kind."

In the care files for people who were living permanently at Rastrick Grange we found information about people's life histories and personal preferences. Some of the staff we spoke with were very knowledgeable about people in their care and understood how to support them. For example, during the afternoon one person was unsettled and we saw one of the senior care staff spending time talking with them.

We saw people appeared at ease and relaxed in the home and were comfortable in the presence of staff. We saw people responded positively to staff with smiles when staff spoke with them. We observed staff included people in conversations about what they wanted to do and explained any activity prior to it taking place.

We saw some people looked well cared for because staff had supported them to dress appropriately and had brushed or combed their hair before they came into the lounge. However, this was not the case for everyone. We saw one person was not given a serviette or apron to protect their clothing at breakfast time. After breakfast we saw they had food spills on their clothing but no one took them to change their top. We also saw one person had dried blood on their top lip and finger throughout our visit. Staff did not support them to wipe their face or wash their hands.

When we looked around we saw bedrooms were personalised with people's own possessions, photographs and personal mementos. This helped to make each room personal and homely for the person concerned.

Whilst all people at the home had the support of families and friends our discussion with the registered manager showed they had a good insight into the requirements to provide unsupported people with lay advocacy or if appropriate an independent mental capacity advocate (IMCA).

When we looked at the care plans we saw they held 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions. The correct form had been used and was fully completed recording the person's name, an assessment of capacity, communication with relatives and the names and positions held of the healthcare professional completing the form. Staff knew about the DNACPR decisions and were aware these documents must accompany people if they were to be admitted to hospital.

Visitors we spoke with told us they were made to feel welcome and said staff were very friendly. They also told us staff would make them a drink or they could do this themselves if they wanted. Relatives also told us they could stay for a meal if they wanted to.

Good

Is the service responsive?

Our findings

Staff said at handovers when shift changes occurred they were told about people's daily care needs. For example, if someone had a sleepless night or if someone had fallen. Another member of staff said daily reports kept them informed about people's daily activities and wellbeing. We witnessed the handover from night to day staff and saw staff followed up on two of the messages given. We saw the night records accurately recorded what had been handed over. We also saw staff paid attention to the needs of one person who had exhibited a degree of adverse behaviour and had slept poorly. Staff ensured the person had a restful morning and was protected from any anxiety.

In the care files we looked at we saw people had been assessed before they were offered a place at Rastrick Grange, to make sure staff could meet their care needs. These assessments were then used as the foundation to create a care plan. We spoke with two social workers who confirmed the registered manager always assessed people before admission and told us placements they had made had been very successful.

We looked at ten care files and found they were easy to navigate and followed a standardised format. All of the files contained detailed risk assessments relating to activities of daily living such as mobility, eating and drinking and continence. Where risks had been identified measures had been put in place to mitigate those risks.

Care plans recorded what the person could do for themselves and identified areas where the person required support. Where people required support the care plan described this in terms of numbers of staff and any equipment needed. For example, one person had been assessed as needing hoisting from a chair to a wheelchair and vice-versa with the help of two care staff. We saw the hoist being used as specified. Staff monitored the care people received and took appropriate and timely action to ensure people remained supported and safe. People received care as identified in their care plans.

We saw relatives had participated in the compilation and reviews of care plans. This was particularly so with people who had appointed attorneys or the Court of Protection had appointed deputies.

We spoke to two relatives about the provision of activities who told us, "They used to have singers and entertainers coming in but all of that seems to have dried up."

On the day of our inspection one of the bank care workers was working as the activities co-ordinator across all three floors. We saw they put various books, puzzles, musical instruments on the tables in the dining areas for people to use. They also spent time with people on a one to one basis engaging them in conversation or singing.

One person had been admitted for a short stay at the home on the day of our inspection. We saw after their relatives had left they became tearful. The activities co-ordinator quickly offered them reassurance and engaged them in a discussion about dogs, using a book and pictures to generate discussion. This helped the person settle and we saw they enjoyed the one to one attention.

We also saw two of the care staff were very skilled in engaging with people on an individual basis to provide them with some occupation. However, we saw there were a lot of missed opportunities to involve people in daily life at the home for example, getting people to help set the dining tables, make drinks or wash up.

Some people we spoke with told us they had no complaints about the service but knew who they should complain to. One person said, "There is nothing to complain about." Relatives we spoke with told us they would feel able to raise any concerns with the registered manager or another member of staff. We looked at the complaints log of and saw both written and verbal complaints had been recorded. We found complaints were not a common feature of the service with only three having been received in the past year. Complaints were handled well with a clear auditable trail of actions taken. We saw no pattern to the type of complaint or evidence of a recurrent theme.

Requires Improvement

Is the service well-led?

Our findings

The registered manager is responsible for Rastrick Grange and another service of the same size next door. They told us there had been recent changes to the senior team and the care manager and deputy manager were both new in those roles.

We found the registered manager to be open and honest in their response to the inspection visit and allowed inspectors free access to staff, people using the service and relatives. This meant the inspectors were able to form an accurate assessment of what was working well within the service and what areas required improvement.

Staff told us the registered manager provided good leadership and always wanted the best for people using the service. They told us various fundraising activities had been arranged to make improvements to the home. For example, the café on the first floor had been created by staff to give people and their relatives a social area to use.

We saw the registered manager was completing a range of audits, for example, audits of falls, weights, pressure sores, skin tears and infections. We saw these audits were effective and resulted in action being taken to reduce any identified risks to individuals.

We saw staff training audits were taking place and any training which was out of date was being highlighted. Staff told us they were reminded to update their training by the registered manager or care manager.

We looked at the accident records and saw action was being taken in relation to any individual who had more than one accident. However, there was no further analysis of the accidents to look at, for example, the location, time of day, or whether the accident had been witnessed or not to see if there were any common themes or trends.

We asked to see the environmental audits, however, the registered manager told us there were none being completed. They told us staff reported any issues to the handyperson and then they were repaired. Although the communal areas of the home had been redecorated and refurbished we saw other areas of the home which required some general improvement, but could not find how this was going to be achieved in any planned way.

We asked the registered manager about medicines audits. They told us they had recently attended a training session and would be conducting future audits from data held on the computerised system, but these were not in place yet.

We asked the registered manager what tool they used to decide on safe staffing levels. They told us there was a dependency tool but this had not been used recently. Without the use of a reliable dependency tool there would be no guarantee the staffing levels in the home would be adequate to meet people's needs. We found staffing levels were not adequate showing the monitoring systems in this area were not effective.

We wanted to know how people using the service and relatives were consulted about the way the service was managed. We saw the last residents and relatives meeting had been held in April 2015. The registered manager told us meetings should be every six months, but head office had rescheduled the meeting which should have taken place in October 2015 to February 2016. At the meeting in April 2015 people had asked for managers to be available outside of office hours. In response to this the registered manager had set up monthly surgery sessions between 5:00pm-6:00pm.

We also saw five visitors surveys which had been completed before the closing date of 1 February 2016, One person had written, "I have filled these in before and nothing happens." One of the questions on the survey was, 'Are you invited to social events in the home?' One person had responded, "Nothing happens." Another question was 'Are you encouraged to support your relative on outings from the home?' One response was, "No trips out." This showed us the surveys were not specifically written for the service provided at Rastrick Grange and people did not feel their comments would be listened to and acted on.

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

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not operated effectively to assess, monitor and improve the quality of the services provided or to act on the feedback they received from relevant persons. Regulation 17 (1) (2) (a) (e).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed. Regulation 18 (1).