Orchard Care Homes.Com (2) Limited

Rastrick Hall & Grange

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 13 and 14 November 2018. The first day was unannounced; the provider knew we were returning on the second day.

Rastrick Hall and Grange is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home provides nursing and personal care for up to 79 older people, some of whom may be living with dementia. Accommodation is provided in two adjoining buildings Rastrick Hall and Rastrick Grange. Each building has three floors with passenger lift access between floors. All bedrooms are single rooms with ensuite facilities. There are communal areas on each floor, including a lounge and dining room. There were 72 people in the home when we inspected.

At our last inspection on 10 May 2017 we rated the service as 'Good'.

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

Risks to people were not properly assessed or managed well, putting people at risk of harm or injury, particularly where people displayed behaviour that challenged others. Accidents and incidents were recorded, however, the analysis of these was poor with little evidence to show lessons had been learnt or actions taken to improve safety.

Some aspects of medicine management were safe. However, there were concerns about the storage of some medicines as fridge temperatures exceeded the recommended safety range and no action had been taken to resolve this.

We found there were not always enough staff to meet people's needs and keep them safe.

Staff recruitment procedures ensured staff were suitable to work in the care service. Staff completed induction and were up to date with most of their training. However, they lacked the skills and knowledge in how to manage behaviour that challenged which put people who used the service and staff at risk of harm and injury. Staff said they felt supported and received supervision and appraisals.

Staff had received training in safeguarding and understood the reporting systems. Safeguarding incidents were recorded and reported to the local authority safeguarding team.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People's care records were not personalised and did not reflect people's needs or preferences. There was not enough detail to guide staff about the care and support people required. People's nutritional needs were met, although the monitoring of people's fluid intake needed to improve. People had access to healthcare services and systems were in place to manage complaints.

People and relatives told us activities were limited which our observations confirmed. Relatives told us staff were kind and caring. We saw some caring interactions but also practices which showed a lack of respect for people and compromised their privacy and dignity.

The registered manager acknowledged they had struggled to complete management tasks due to staff turnover and absences. The provider had arranged additional support however staff had only just started in these posts when we inspected. The provider's systems and processes did not enable them to effectively assess, monitor and improve the service. They did not monitor and mitigate risk effectively.

We found shortfalls in the care and service provided to people. We identified five breaches in regulations; staffing, safe care and treatment, dignity and respect, person-centred care and good governance. The Care Quality Commission is considering the appropriate regulatory response to resolve the problems we found. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People received their medicines when they needed them, however the storage of medicines was not safe.

Staffing levels were not sufficient to meet people's needs and keep them safe. Staff recruitment checks were thorough.

Risks to people's health, safety and welfare were not managed well placing them at risk of harm or injury. Safeguarding incidents were recognised and reported.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received the induction, training and support they required for their roles, although training in managing behaviours that challenged needed to improve.

The service met the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

People's nutritional needs were met, although the monitoring of people's fluid intake needed to improve. People had access to healthcare professionals. The environment was designed to meet people's needs.

Is the service caring?

Requires Improvement

The service was not always caring.

Although we observed some kind and caring interactions, we found people were not always treated with dignity, kindness or respect.

People were not always involved in planning their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not receive personalised care that met their needs and preferences.

Activities were provided, however these were limited.

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

Is the service well-led?

Inadequate

The service was not well-led.

Leadership and management of the service needed to improve.

The provider did not have effective systems and processes in place to assess, monitor and improve the service or assess, monitor and mitigate risk.

Rastrick Hall & 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 checked 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 13 and 14 November 2018. The first day was unannounced. The team consisted of three inspectors, two specialist professional advisors (one in governance, the other in medicines), and an expert by experience with experience of services for older people. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day, the provider knew we were returning and two inspectors attended.

We brought this inspection forward due to concerns we had received about insufficient staff at night, people having to get up in the early hours of the morning, staff not using moving and handling equipment and a lack of staff training in how to manage people who display behaviour that challenges others. On the first day of the inspection, two inspectors arrived at 5.50am so they could speak with the night staff and check when people were getting up.

Before the inspection we reviewed the information we held about the home. This included looking at information we had received about the service and statutory notifications we had received from the home. We also contacted the local authority commissioning and safeguarding teams and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We did not ask the provider to complete a Provider Information Return (PIR) on this occasion. 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 observed how care and support was provided to people. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with ten people who were using the service, ten relatives, five senior care staff, six care staff, two agency care staff, the chef, an activity organiser, two deputy managers, two care managers, registered manager and the regional director.

We looked at 10 people's care records, three staff files, medicine records and the training matrix as well as records relating to the management of the service. We looked round the building and saw people's bedrooms and communal areas.

Inadequate

Is the service safe?

Our findings

Risks to people were not well managed which placed people at risk of actual and potential harm or injury.

Some people displayed behaviours which challenged others who lived in the home, visitors and staff. Risk assessments had been completed, however the plans to manage these risks were not robust. Two people were on 15 minute observations due to incidents that had resulted in harm or injury to other people who used the service and staff. The registered manager told us both people were monitored by staff at all times and these observations were for staff to record where the person was, what they were doing at the time and their behaviour so they could identify any triggers. We reviewed the observation records for both people and found these only listed where the person was, for example, in the lounge or hallway. There was no information about the person's mood state or other information to help staff understand and anticipate triggers or reduce the impact on people by providing distraction or other meaningful activity. We observed both people were continually walking around with little to engage or interest them.

We observed one person in a communal area for one and quarter hours; during this time staff were not always present and no observations were recorded. We had to intervene and ask staff to attend when the person began to pull at another person's clothing. Records showed other occasions when staff had not recorded their observations. No action had been taken to address this. We asked one unit manager what they did with the monitoring forms once staff had completed them, and they told us, "They bring them to the office and I put them in a file." This meant opportunities to review the effectiveness of risk management processes were not taken.

An incident had occurred six days before our inspection. A person had locked themselves in a bedroom and refused to open the door. The staff were unable to find a key to open the door. The fire brigade attended and had to force the door from the frame causing damage to the door frame. The person was unharmed. The provider had checked all the other bedroom doors and identified there were no keys for two other bedrooms. A locksmith attended and removed the locks from these doors and new locks were ordered. However, no one had considered that the removal of these locks affected the fire protection as there was now a hole in the door. We raised this with the provider on the first day of our inspection and temporary locks were fitted that day. We also raised concerns about the door frame which was splintered and jagged posing a risk of injury to the person whose room it was and staff. Also the bedroom door could not be closed or locked due to the damage. The area manager and registered manager told us this would be addressed and they would arrange for the person to be moved to another bedroom that night.

When we returned on the second day staff told us the person had moved into another bedroom and slept there. However, we found nothing had been done to repair the door frame which remained a hazard. When we raised this with the registered manager they took action, however, we were concerned this risk had not been resolved.

Records of individual incidents and accidents showed further opportunities to reduce the risks associated with behaviours that challenged were also missed. Forms lacked information, even where this was

prompted. For example, sections relating to what had been learnt about the person and their behaviours were not completed. There was no indication that incidents were reviewed over time to enable emerging themes to be identified and used to improve risk management in this area.

We saw the provider's processes for incident management included root cause analysis. This is a tool used in healthcare to support investigation into the causes of incidents and the identification of lessons which can be learnt to prevent repeat occurrences. Records we reviewed were not completed to a good standard. There was no evidence of thorough investigation, analysis of what had happened was weak, and there was a lack of conclusion as to what could be done differently in future.
We concluded people were not always receiving safe care and treatment in relation to risk management. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the systems in place for storing medicines were not always safe. The home has six clinic rooms each containing a medicine fridge. Medicines stored in a fridge must be kept at between 2 and 8 degrees centigrade (2°C – 8°C) and must be monitored daily to ensure the temperature remains in this safe range. Five out of the six fridges we inspected were above 8C° and records showed this limit had been exceeded on several occasions. The last recorded temperature for one fridge was 16.6°C on 3 November 2018, no temperatures had been recorded since. Another fridge had a temperature over 18°C every day since 1 November 2018. Both fridges contained medicines. There was no evidence to show this had been reported to the registered manager or that any action had been taken to inspect or repair the fridges.

We found additional stock of medicines was stored in cupboards in the clinic rooms. Medicines in care homes are prescribed for named individuals. However, due to the lack of space, the stock was stored collectively rather than separately for each named person. For example, we saw many boxes of one medicine prescribed for different people all together in one cupboard. This meant there was a potential risk that other people's stock medicines may be used instead of those prescribed specifically for a person.

We concluded people were not always receiving safe care and treatment in relation to medicine storage. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other aspects of medicine management were safe. Medicines were kept securely and only trained staff had access. Staff had received medicines training and had their competency checked. Our discussions with staff showed their knowledge about medicines was good. We saw medicines were administered to people safely and correctly. Medicine administration records were well completed. Protocols were in place for medicines prescribed on an 'as required' (PRN) basis. Some medicines require additional secure storage and management because of the nature of the drugs they contain. These are known as 'controlled drugs'. These medicines were managed safely.

We found there were not enough staff to meet people's needs and keep them safe. When we arrived at 5.50am on the first day of the inspection there were 11 staff on duty for 72 people (six staff on Rastrick Grange and five staff on Rastrick Hall). Five out of the 11 staff were agency staff. Staff told us, and the registered manager confirmed, these were the usual staffing levels. We spoke with six night staff who gave mixed feedback about the staffing levels. Three staff felt there were enough staff, the other three said they often struggled and felt they needed more staff.

We saw some people were already up and dressed in the communal areas. Staff told us they started getting people up at 5.30am and only got up those who wanted to. We observed some of the people who were up

were asleep in their chairs and did not have drinks, although these were provided as the morning progressed. We saw one person at 6am. They told us staff had got them up at 5am and said, "I haven't had a drink. All I want is a nice cup of tea with no sugar. I go to bed early and get up early. It's like a reform school, I think what have I done wrong."

People and relatives gave mixed feedback about staffing levels. Comments included: "There are too few staff, I have come in some mornings and not been able to find anyone"; "I think there are enough staff. There is a good response from staff when mum needs assistance"; "More staff would be better" and "They could do with more staff."

The registered manager told us they were recruiting for care staff and senior care staff on nights and days. They advised they were using agency staff to maintain night staffing levels at six on the Grange at night. They said there should be six night staff on the Hall as well but had been told by senior managers that the levels remained at five until care staff had been recruited to the post. This was confirmed in a recent report we saw completed by the head of regional operations.

The registered manager used a dependency tool to calculate safe staffing levels, however, they were unable to describe to us how the tool worked and there was no formal reporting of whether the correct staffing levels had been achieved. The dependency audit tool we were shown dated 31 October 2018 had not been calculated correctly. An incident report for one person also identified there were times when there were insufficient staff to meet people's needs and keep them safe. The report dated 2 November 2018 showed one person had gone into another person's room and spat in the person's food and sworn at them. The section showing the action taken following this incident stated; "We try to observe where possible every 15 minutes but due to demands from other residents this is not always possible." We concluded there were not always sufficient staff to keep people safe or meet their needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

New staff were recruited safely with all required checks completed before they started in post, including a criminal record check and references.

People told us they felt safe in the home and relatives agreed. Staff had completed safeguarding training, understood how to recognise possible abuse and the reporting procedures. They were confident any concerns raised would be dealt with appropriately and knew the external agencies they could contact if they felt this had not happened. Safeguarding incidents were recorded and referrals had been made to the local authority safeguarding team.

People and relatives told us the home was kept clean. We found standards of cleanliness were good apart from two bedrooms where there were malodours. Staff told us new flooring had been ordered for one bedroom and was due to be fitted in the near future. The registered manager took action in response to the other bedroom. We saw staff followed good infection control practices, washing their hands and wearing personal protective equipment (PPE) such as gloves and aprons appropriately.

Regular checks were carried out on the premises and equipment to help keep people safe. We saw up to date certificates in place for regulatory checks on gas, electric, water, hoists and fire systems. However, records of weekly and monthly checks carried out by maintenance staff were not always up to date. For example, weekly checks of fire alarms, door alarms, nurse call alarms, exterior lighting and passenger lifts had not been completed since 1 October 2018. There was a list of monthly checks which included water temperatures and bed rail checks. There was no evidence to show these checks had been completed. The registered manager said they would look into this matter.

Staff had received fire training and knew the procedures to follow in the event of a fire. Fire drills were carried out regularly. The fire risk assessment review date was 11 October 2018, however the review had not been completed. The registered manager was following this up with head office. Personal emergency evacuation plans (PEEPS) were in place which outlined the support each person would need from staff if they needed to be moved in an emergency situation.

Requires Improvement

Is the service effective?

Our findings

Staff received the induction, training and support they required to meet people's needs. New staff completed a corporate induction and were supervised in post for the first three weeks of employment. Staff who had no previous care experience completed the Care Certificate. The Care Certificate provides care workers with standardised training which meets national standards. Our discussions with staff and review of records confirmed these processes were followed.

Staff confirmed they received ongoing training which included areas such as moving and handling, safeguarding, health and safety, nutrition and equality and diversity. Training was mainly online with some practical sessions in areas such as fire safety and moving and handling. One staff member said, "There's lots of in-depth information included if staff want to follow things up." Training was monitored by the registered manager and the provider to make sure staff were kept up to date. Staff told us they were supported to achieve additional qualifications in care.

The training matrix showed the majority of care staff had received training in understanding and managing behaviour that challenges, which was updated every three years. The registered manager confirmed this was online training. However, two of the night staff we spoke with told us they had not received this training while employed at the home, although both had received this training in previous employment. Incident reports we reviewed showed staff had received injuries from people who displayed behaviour that challenged. We asked the registered manager if staff had received any additional training to support them in managing these situations so they knew what to do to keep themselves and others safe. The registered manager said no and agreed staff would benefit from more indepth training in this area.

Staff told us they received regular supervisions and annual appraisals. The registered manager had a plan in place to ensure these were completed for all staff.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals 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.

We found the service was working within the principles of the MCA. Staff had received training in MCA and DoLS and had a good understanding of the principles. Systems were in place to enable unit managers to manage the DoLS processes. This showed when DoLS applications had been submitted, authorisation dates, renewal dates and whether any conditions had been attached to the authorisation. Where people had a DOLS authorisation this was highlighted in the care plan, which also showed how any conditions were

to be met. We found more robust action was needed to meet a condition on one person's DOLS and brought this to the attention of the registered manager who told us they would take action.

Care plans showed how people's capacity to make a range of decisions was assessed, and we saw records of best interest decisions being made when people lacked capacity. Care plans contained signatures of people or their relatives to show consent had been obtained for care and treatment, however there was a lack of explicit consent for equipment such as sensor mats which had been placed in people's rooms.

We saw staff asked people for their consent before providing care, for example when assisting people to move or supporting people to find their way around the home.

People's nutritional needs were met, although the recording and monitoring of food and fluid intake needed to improve. For example, one person's care records showed they had chronic kidney disease and their fluid intake was being monitored. There was no information in the person's care records to show how much fluid the person should be having on a daily basis. We looked at the fluid records for this person from 22 October to 14 November 2018 which showed the average daily fluid intake over this period was 820mls. We saw on some days very little fluid had been recorded. For example, on 8 November 2018 the daily fluid intake was 365mls; on 10 November 2018 it was 600mls. We spoke with senior care staff and the registered manager about these recordings; the lack of fluid intake had not been identified or addressed. The registered manager said they would take action to ensure this was addressed.

People and relatives made the following comments about the food; "The food is plain but good"; "The food is not marvellous but eatable and average"; "Could be better food, too many sandwiches" and "The food is okay, [family member] is on a soft diet."

We saw people having lunch in the dining rooms. Tables were nicely set with floral displays, cloths, napkins, glasses and condiments. Staff asked people what they would like and showed them the different meals on offer so they could make a choice. The meal was nicely presented and looked appetising. Drinks were offered and staff were present, prompting and encouraging people. Where people needed one to one assistance from staff this was provided. A selection of drinks and snacks were available throughout the day which people could help themselves to or ask staff to assist them. We saw staff regularly asked people if they wanted a drink or anything to eat.

We spoke with the chef who was knowledgeable about people's individual dietary requirements, a record of which was kept in the kitchen. Catering staff attended the daily 'flash meetings'; these communication meetings involved a representative from each department so everyone was updated on any changes. Menus were devised on a four weekly rota and changed seasonally. There was a choice of meals available and other options such as baked potatoes, for those who did not like what was on the menu. Specialised diets were provided including diabetic diets and pureed, soft or blended meals for those with swallowing difficulties. The chef confirmed plentiful stocks of food were maintained.

Some adaptations had been made to make the environment dementia friendly and assist people in finding their way round the home. Contrasting colours were used to help people distinguish different objects. For example, handrails in corridors were different colours to the walls, bedroom doors were different colours with large numbers and a sign for the person's name and a picture. Bathrooms and toilets were clearly signposted. Communal areas were bright and comfortably furnished. However, we found there was little to engage or stimulate people.

People's needs were assessed before they moved into the home. The assessments we reviewed had not

been dated or signed by the staff completing them. Information about people's care needs was limited.

People's healthcare needs were met. Care records we reviewed showed input from GPs, speech and language therapists, chiropodists, opticians, the care home liaison team (CHLT) and the mental health team. Care plans we reviewed lacked evidence that people had regular access to dentists, which we discussed with the registered manager. They told us this was not the case, and said they would check to ensure staff understood where this information should be recorded.

Requires Improvement

Is the service caring?

Our findings

Although we observed the majority of staff were kind and caring in their interactions with people, we also saw practices which showed a lack of respect for people and compromised their privacy and dignity.

One relative told us their family member wore glasses and had dentures. They said, "[Family member's] false teeth have never been in [their] mouth. They are in [their] bathroom. [Family member] arrived wearing glasses, they are in [their] drawer. I have never seen [family member] in them." We checked the person's care records which stated their dentures had gone missing when they were in hospital in May 2018, yet when we checked the person's room we found the dentures were in a denture pot in the bathroom, dry and dirty. Staff we spoke with were not aware the person had dentures. The person's care plan also identified they should be wearing glasses, however we saw the person was not wearing them. We raised this with staff, yet no action was taken and the person was without their glasses on both days of the inspection.

On the first day of the inspection we saw a staff member got a hairbrush out of their pocket and used it to brush three people's hair in the lounge. Another person had been assisted by staff to wash and dress and was in the lounge smartly dressed but had no socks on. The person was rubbing their feet and said to us, "I could do with some socks on." We raised this with the registered manager who arranged for staff to find the person some socks. Another person was wearing a skirt but had no tights or socks on. They kept saying they were cold. The person told us they usually wore tights and said, "I don't know why I haven't got any on."

Staff told us one person frequently accessed another person's bedroom and sometimes slept there, which meant the person whose room it was had to sleep elsewhere. This was the bedroom where the door frame had been damaged when the fire brigade had to force the door to gain access. Our inspection took place six days after this incident, yet no consideration had been given to protecting the privacy and dignity of the person who lived in this room. The bedroom door could not be locked or closed due to the damaged frame. When we looked in the room, the bed was stripped with the bed clothes piled up in a chair, the drawer in the bedside cabinet was broken and a picture had been removed from the wall. The room smelt strongly of urine. When we showed the bedroom to a staff member they told us it was like this because of the actions of the other person who kept going into the room. When we raised these issues with the registered manager they arranged for the person to move to another room. However, when we returned the next day we found the person's clothing and toiletries had not been moved with them into their new room.

Staff showed us another person's bedroom. They told us the person was non-compliant with personal care. There was a strong odour of faeces in the room, a towel on the armchair was stained with faeces and when we pulled back the bed clothes there was dried faeces on the sheet. We raised this with the registered manager who took action. We concluded these examples demonstrated people's privacy and dignity was not respected and promoted. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people and relatives we spoke with said the staff were kind and caring. Comments included: "They are very kind occasionally a grumpy one, maybe having a bad day"; "Two girls came to look after me, they are

lovely"; "Carers vary some nicer than others"; "The staff are caring and pretty fair" and "The majority of the staff are devoted to their job and calm."
Staff were caring and discreet when they spoke with people. For example, we saw staff used appropriate humour and touch when communicating, and went to the person's eye level when speaking to someone who was seated. When one person became agitated and distressed we saw a member of staff go and sit with them, talking quietly with them until they became calm again. We heard them use phrases such as, "It's alright," and "No need to worry."

We also observed positive interactions where staff engaged with people sensitively and demonstrated positive regard for the person's wellbeing. We saw some staff sat and chatted with people and clearly knew them well. We saw these staff took every opportunity to chat with people about their families, their interests and what they might like to do that day. However, this was not consistent in all parts of the home or over the two days of our inspection. We saw occasions when staff were present in communal rooms but did not engage with people or provide stimulus. We observed some staff were more focussed on tasks rather than people and their wellbeing.

The majority of people looked clean and well groomed and had been supported by staff to maintain their appearance. We saw any assistance people needed with personal care was carried out in private.

Although staff told us people and their relatives were involved in care planning; care records we reviewed lacked evidence of people's involvement. Care plans and reviews were not signed to record the participation or agreement of people and their relatives. Information recorded about people's life histories was inconsistent as these had been completed for some people but not for others. Life histories can be a valuable source of information to assist staff in building caring relationships with people. One care plan had a note stating the 'This is me' document had been given to the person's family to complete, however staff had done nothing to document anything they had been able to learn about the person.

Requires Improvement

Is the service responsive?

Our findings

People were not always receiving personalised care. Care plans did not always contain sufficient or up to date information about people's needs or the support they required from staff.

Staff were working with two care record systems; the majority of care plans were in paper format in files and a new electronic care record system had been in place for two months. Staff had received training on the new system and had been issued with hand held devices which they used to access care information, record daily notes and update care charts. Staff said they liked the new devices and said it meant they could quickly and easily access information about people and update records in real time. The registered manager told us they were in the process of transferring all the care documentation onto the new system and were aiming for this to be completed by the end of January 2019.

We found the two recording systems did not support timely and responsive care and support. Care plans we reviewed lacked a clear sense of how staff could provide person-centred care. Guidance was often vague, and detail was lost in reviews, meaning it would be hard to track people's up to date needs. For example, one person's care plan dated 13 November 2017 showed the person displayed verbal and physical aggression and advised staff to use distraction techniques. There was no guidance for staff on what distraction techniques to use other than to move the person into their bedroom. Another person had been admitted to the home in July 2018 and a respite care plan had been put in place. This was still in place and had not been updated. We saw weight records showed the person had lost 5.1kgs in weight between 30 July 2018 and 8 October 2018. This weight loss was not reflected in the person's care plan and there was no evidence to show what action had been taken in response. We looked at the care plans for another person who had been the victim in two incidents involving other people in the home. Staff were aware the person was vulnerable to these situations occurring, however, there was nothing in the person's care plans about this or what action staff could take to protect the person.

We found daily records made on the electronic care system made observations about people's moods which did not tally with the rest of the entry. For example, one entry read; "Refused help with toileting started getting angry, was happy."

People and relatives felt there were not always enough activities. Comments included; "The activities are not very good. The occasional act comes in but nothing doing. They used to have bingo on a Sunday but not now" and "Would be better if [they] could be taken outside more."

One relative whose family member had been in the home since January 2018 said, "I've not seen any activities or trips, getting access to the garden is difficult as they keep big wire delivery trolleys blocking the path." We saw the trolleys blocked the access to the garden on both days of our inspection.

We saw some people took part in a bingo session and others attended an exercise class. However, we found most of the time there was little going on for people in the communal areas other than the television or music playing.

We observed a small number of people living with dementia in one lounge. We saw staff were present but frequently failed to interact with people. We saw people's moods remained consistently neutral and they lacked opportunity to engage in meaningful activity. For example, the television was on but none of the people in the lounge were watching it and we did not see staff ask what programme they may wish to view.

The provider employed two activity organisers who each worked four hours a day Monday to Friday. These hours spanned lunchtime when the activity staff supported people with their meals. The registered manager had recognised the current hours were not sufficient to meet people's needs and was in discussion with the provider about increasing this provision. A weekly activity programme was displayed showing daily activities including exercises, bingo, table top activities and beetle drive. There was a religious service held every month. Once a week a minibus was booked to take out four to five people. There had been trips to Shibden Hall, Kirkstall Abbey and local garden centres.

The registered manager told us no one in the home was currently receiving end of life care. There was no evidence in the care records we reviewed to show discussions had taken place with people and/or their relatives to determine their wishes and preferences in relation to end of life care.

We concluded people were not receiving personalised care that was responsive to their needs and wishes. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives we spoke with knew how to make a complaint. However, one relative told us, "When I have rung to complain I'm told that someone will get back to me, but no one ever does." The complaints procedure was displayed in the home. The registered manager told us written complaints were sent to head office, who sent out acknowledgement letters. The registered manager said they investigated the complaint, where appropriate, and sent their report to head office who sent out the response to the complainant. Verbal complaints were dealt with by the registered managers. We saw a complaints log was maintained which showed the actions taken in response to each complaint.

Inadequate

Is the service well-led?

Our findings

We found ineffective leadership and management. Quality assurance systems were not robust in identifying and resolving issues.

There was a registered manager in post. Most people and relatives knew the registered manager and said she was approachable. The following comments were made: "[The registered manager] is always on the end of the phone" and "Sometimes the manager stays back so she is able to talk to us."

Staff told us they liked working at the home and felt supported by the management team. Comments included; "It's a great place to work because of the staff. The managers come and chip in if we need them"; "It's a good place to work so far"; "Management is good"; "There has been a lot of upheaval recently and staff morale has been poor" and "I wasn't positive about working here but that has now changed as we all know each other. In my opinion things are getting better and we are now not relying on agency staff"

The registered manager acknowledged they had struggled to complete all their management tasks in recent months due to staff turnover and vacancies. The home had been without administrative support for over two months due to maternity leave and there were vacancies for senior care staff and a night manager. The provider had taken action to provide the registered manager with some additional support, for example, appointing another care manager to act as deputy and providing temporary administrator support. However, these staff had only started in post the day before the inspection so the benefit of their support was not yet apparent.

We found records were disorganised. On the first day of the inspection staff could not locate any care plans for a person who had been admitted in October 2018; there were no care plans on the computerised system and the paper care record had gone missing. These were found amongst other records the following day. We saw boxes with paperwork including complaints, accident and incident reports and other records were in the office waiting to be sorted.

We found some records were inaccurate. For example, we were told and paper records showed an incident had occurred on 7 November 2018 at 01.50. Yet when we checked the electronic care records of the people involved in the incident there was no mention of it. It became evident when we spoke with the care manager that the wrong date had been entered on the incident form, the notification form to CQC and the root cause analysis document.

We found communication between staff needed to improve. For example, staff told us they had raised concerns about the damaged door frame but no action had been taken. We attended the handovers between night and day staff on both Rastrick Hall and Rastrick Grange. We found the information provided about people's needs was limited and did not included everyone in the home. For example, only eight of the 35 people living in Rastrick Hall were mentioned in the handover.

We saw the provider had governance systems in place which relied on the registered manager submitting

information about all aspects of service delivery. We saw records which showed this information was analysed at corporate level and lessons learnt were shared with the provider's services. However, we found systems for capturing and managing organisational risk at home level were ineffective. For example, minutes of the clinical governance meeting, dated 12 November 2018, completed by the registered manager, had a section to report on people with weight loss of over 2kgs. One person's care records we reviewed showed when they were last weighed in October 2018 they had lost 5.1kgs. This person was not included in the analysis. The minutes also reported on safeguarding, accidents and incidents and serious untoward incidents. However, was there no reference to three incidents that had occurred with one person involving a visitor being hit, a staff member being assaulted and the fire brigade having to attend to release the person from a bedroom as staff could not find a key to open the door.

We found investigations into concerns raised by staff were not sufficiently thorough and actions were not taken promptly, putting people at risk of harm. Disciplinary procedures had not been completed and a referral had not been made to the disclosure and barring service until the provider was prompted to do so by the local authority.

The head of regional operations carried out bi-monthly visit reports. We saw a copy of the most recent visit carried out in October 2018. Actions had been identified for the registered manager to complete. However, the report did not identify the issues we found at our inspection and there was no evidence to show the views of people who lived in the home or staff had been sought as part of the visit.

Residents meetings were held giving people an opportunity to air their views. The registered manager told us the format of these had been changed to focus on asking people what they wanted so they could make improvements. We saw minutes from meetings held in February, March, May and July 2018 by one of the activity organisers. The format was the same at each meeting asking people where they would like to go on trips, did they want any food changes, suggested pets for the home and any new activities they would like. We saw similar things had been suggested by people at every meeting, yet there was no evidence to show any of the suggestions had been acted upon as there was no feedback at subsequent meetings.

A residents and relatives meeting was held in September 2018. The minutes showed a wide range of topics were discussed. Concerns were raised about missing laundry and the lack of activities. It was not clear what actions had been taken to address these matters.

We saw minutes from the last staff meeting held in July 2018. These showed a range of topics were covered giving instructions to staff on actions they had to take. However, there was nothing recorded to show any issues raised by or feedback received from staff.

We concluded there were significant shortfalls in the leadership and governance arrangements. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The previous inspection ratings were on display in the home and on the provider's website as required under legislation.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People who use the service did not receive care and treatment that was appropriate and met their needs and preferences. Regulation 9(1)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People who use the service were not treated with dignity and respect. Regulation 10(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed to meet the needs of people who used the service. Regulation 18(1)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use the service were not provided with safe care and treatment as risks to their health and safety were not assessed and the provider had not taken all reasonably practical action to mitigate the risks; and medicines were not managed safely. Regulation 12(1)(2)(a)(b)(g)

The enforcement action we took:

Warning notice

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 established and operated effectively to assess, monitor and improve the quality of services or to assess, monitor and mitigate the risks relating to the health, safety and welfare of people who use the service and others; and there was not an accurate, complete and contemporaneous record in respect of each person using the service in relation to the care and treatment provided. Regulation 17(1)(2)(a)(b)(c)

The enforcement action we took:

Warning notice