

The Old Rectory Nursing Home (Doncaster) Limited

The Old Rectory Nursing Home

Inspection report

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South Yorkshire
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Tel: 01302832032

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

The inspection was unannounced and took place on 23 September 2016. The inspection was undertaken by two adult social care inspectors. At the last inspection in April 2016 the service was given an overall rating of good.

The Old Rectory Nursing Home provides personal and nursing care and is registered for 36 older people including those living with dementia. On the day of the inspection 36 people were receiving the service, including three people receiving respite care.

The home had a registered manager who had been in post since January 2015. 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.

People told us they felt safe and well cared for and staff we met understood people's individual care needs and had received training. However we found that, some staff training, which was required to be updated annually had not been provided in timely way, to ensure people who used the service were safe at all times.

There were good links with health and social care professionals. However, we found a small number of instances when staff had not always acted upon the advice received, so that people's needs were not always met.

Although the registered manager, people and their visitors told us there were enough staff to keep people safe, some staff told us there were busy times during the day when it became difficult to meet everyone's needs.

Pre recruitment checks were undertaken before staff started work in the service. However, there were occasions when the provider had accepted personal references, rather than pursuing references from applicants' previous employers.

People and their visitors expressed very positive views about the staff and the care provided. Staff were kind and caring in their approach and interacted with people in a positive way.

People were cared for by staff that demonstrated knowledge of the different types of potential abuse to people and how to respond to actual or suspected abuse.

People told us they enjoyed meal times and were positive about the choice of food they received.

People said their privacy and dignity was maintained and our observations supported this.

People were encouraged to express their views and give feedback about their experience of the service. People said staff listened to them and they felt confident they could raise any issues should the need arise.

Staff spoke highly of the teamwork within the service.

The quality of service provision and care was monitored and actions taken to improve the service where required. However, the quality monitoring system had failed to identify and address the shortfalls we found at this inspection and some issues that had been identified had not been addressed in a timely way.

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.

Although the staff who administered medicines were qualified to do so, there were gaps in the records of people's medicines.

Not all staff had up to date training in moving and handling people.

Sufficient numbers of staff were on duty to keep people safe; although staff told us they sometimes struggled to meet people's needs at key times.

Pre recruitment checks were undertaken before staff started work in the service, although there was room to improve the records regarding the acceptance of personal references.

The provider had arrangements to respond to suspected abuse. Staff received training in safeguarding people and a clear policy was in place for staff to follow.

Is the service effective?

Good 

The service was effective.

Most staff had received training to ensure that they could meet people's needs, although the provision of training updates was not always timely.

People's mental capacity was assessed in line with the Mental Capacity Act 2005. Staff always asked for people's consent and respected their response.

People's nutrition and hydration needs were met.

Is the service caring?

Good 

The service was caring.

People were looked after by kind and caring staff.

Staff respected people's choices and preferences in how they

wanted to be looked after.

People's rights to privacy and dignity were valued and respected.

Is the service responsive?

The service was not always responsive.

People received care which met their individual needs?

People had care plans although they were not all up to date or regularly reviewed.

People and their relatives were supported by staff to raise any comments or concerns about the service.

Requires Improvement ●

Is the service well-led?

The service was not always well-led?

There was room to improve the provider's systems to check and improve the quality of the service provided.

People were cared for by staff that felt supported by the management team.

People and staff were encouraged to express their views and contribute to the development of the service.

Inadequate ●

The Old Rectory Nursing Home

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 23 September 2016 and was unannounced. The inspection was undertaken by two adult social care inspectors.

As part of our inspection we looked at the information we held about the service. This included, the last inspection report, notifications received from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law.

The provider had completed a Provider Information Return (PIR). This is information we asked the provider to tell us about what they are doing well and areas they would like to improve?

We spoke with five people that lived at the home, five people's visiting relatives and friends, the registered manager, the registered provider, the quality officer, the general manager, four staff and two visiting healthcare professionals.

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 looked at the care records of two people and the recruitment, training and supervision records for five staff. Other records we viewed included complaints records, minutes of meetings, audits and monitoring records completed by the registered manager and quality manager, and quality questionnaires completed by people who used the service and by staff.

Is the service safe?

Our findings

People told us they felt safe living in the home. We saw that information about keeping safe was on display in the home. Relatives told us they had no concerns about their family members' safety. One relative said, "I visit every day and see people are looked after well, and are safe."

We looked at how people's medicines were managed in the home. We found that people's medicines administration records (MARs) included a picture of them, which reduced the likelihood of error. Most medicines were stored appropriately in a specific room and the temperature they were stored at had been logged and fell within the guidelines which ensured the quality of the medicines was maintained. However, a locked medicine trolley was kept in the dining room, where we noticed it was quite warm, and the temperature of this medication was not monitored.

Staff who administered medicines were qualified to do so. Records detailed what medicines were prescribed and how and when it was to be administered. Previous provider audits had highlighted instances of staff failing to sign and this issue was discussed with the registered manager at the last inspection. There was evidence that the registered manager had addressed the issues with the staff involved. This included taking this up with staff during their supervision, as well as writing to them, listing the times that they had failed to complete people's medicine records appropriately and highlighting the importance of accurate records. However, we noted that in some cases, improvements made by staff had not been sustained. At this inspection a sample of stock was checked and not all matched with the records that were held, as several signatures to indicate that medicines had been administered were missing from the MARs. Handwritten MAR's had not been signed by staff and it was therefore not possible to determine if an appropriate person had written the MAR. Yorkshire and Humber Commissioning good practice guidance suggests that; MAR charts should only be prepared or changed by staff who are trained and competent to do so. We also found medication was left unattended on the medication trolley and an open container of used syringes and needles was also left on a table.

We observed a member of kitchen staff give dietary supplements to a person who used the service. These supplements are prescribed medication and there was no qualified member of staff in the room at the time.

This is a breach of Regulation 12 (2)(g) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had arrangements to respond to suspected abuse. Staff received training in safeguarding adults and a clear policy was in place for staff to follow. Staff we spoke with had a good understanding of what constituted abuse and who to report concerns to. Staff understood what whistleblowing meant and the provider had a policy in place to support staff who wished to raise concerns in this way. Whistleblowing is a route staff can use to raise concerns they may have with staff behaviour or practice concerns. One member of staff said, "I know I could report abuse to the manager and action would be taken, I also know I could talk to the local authority or CQC regarding abuse."

In most instances, risks were managed well. For instance, all relevant risks were recorded in detail in people's care plans including specific steps to take to keep people safe. However, we saw one instance where staff had failed to follow the advice of a healthcare professional in relation to monitoring one person's weight. A visiting dietician wrote in the care plan on 27 July 2016, "Weigh weekly and review in three months." The next and only recorded weight was dated 20 August 2016.

The records we saw showed that there were 10 out of the 40 staff who provided direct care were due to receive training updates regarding moving and handling people in August 2016 or before, so their training renewal dates had been exceeded. At the time of the inspection we saw two staff who worked together to move people, using hoists and slings, when both staff needed training updates. However, we did note that all staff we observed helping people to move around the home, did so safely, competently and confidently, explaining and reassuring people throughout the process.

We spoke with two staff about the information and guidance available to them regarding how to move people safely. They told us that people's needs were clearly stated in their care plans, along with the details of any equipment to be used. They also confirmed that where necessary, occupational therapists were involved, and provided guidance regarding people's specific needs. They told us that if there were any changes in relation to the way a person needed to be assisted to move, this was demonstrated to staff.

The provider told us that training had been planned to be delivered within the appropriate timescale, but that the trainer had become ill, delaying its delivery. All members of the management team were keen to confirm that moving and handling training updates were planned to be delivered to all staff imminently.

The home was generally well presented and smelled and looked clean. Staff had training in infection prevention and control. We saw that the equipment was well maintained and the staff we spoke with and records we saw confirmed that all safety checks of the premises and equipment used had been completed and were up to date.

People we spoke with who used the service said there were enough staff. We also spoke with several visiting friends and relatives who felt there were sufficient staff to meet people's needs. For instance, one person's visitor said, "Yes, there seem to be staff around all the time." We saw that the home was well staffed during our inspection. Most of the staff we spoke with said there were enough staff and that cover was available if staff were absent due to sickness or on annual leave.

However, some staff who told us that there were key times, when it was a struggle to meet everyone's needs within the time available. We also saw that of the 10 staff who completed the last staff questionnaire in late 2015, three had raised issues regarding the staffing available. We were provided with the provider's analysis of the staff survey responses and evidence of action that they had taken in response. This indicated that staffing was related to the numbers and needs of the people who were using the service. The registered manager also told us that they had been working to ensure that staff were deployed effectively and that all staff made the best possible use of their time.

Staff we spoke with said all the required recruitment checks were undertaken before they started working in the home and that they received a good quality induction into their role. We looked at the personnel files for staff and saw that Disclosure and Barring Service checks (DBS) were undertaken before new staff commenced work.

At least two written references were also acquired. However, there were staff who had not provided professional references from their previous employers, and personal references from colleagues had been

taken up and accepted by the provider. The records we saw did not indicate any discussion had taken place with the applicant to clarify this, or provide evidence that any risks arising had been properly considered. We discussed this with the provider and the registered manager gave assurances that they would ensure that records reflected any discussion with applicants regarding the details of the referees they provided, in relation to their previous employment.

Is the service effective?

Our findings

People told us they were supported well by the staff. One person told us, "All the staff are very good, they are kind and they take an interest." The relatives and friends we spoke with told us people were well cared for. For instance, one relative said, "They know [my family member] really well. They have taken the time to get to know what is important." Another person's visitor said, "It's very nice. It's a good home."

We were told that when new staff were appointed they were required to complete the Care Certificate, which is a nationally recognised programme of training for care workers. We saw that staff received the necessary, mandatory training during their induction. This included health and safety, moving and handling, care of substances hazardous to health (COSHH), infection control, fire awareness, and safeguarding people. On-going training was then planned and provided to support staff's continued learning. There was a system to highlight when staff required updates of their mandatory training, although there were some instances when training updates had been provided after their deadlines.

Staff also received training that was specific to the needs of people living at The Old Rectory, such as dementia awareness and pressure care training. The registered manager discussed recent training with staff during their one to one, supervision meetings to identify if there was any learning that could be shared in order to improve the quality of the service.

Staff felt supported through one to one meetings with their line manager. Staff told us they discussed people's care plans, their achievements and changes in needs as well as any ideas or concerns staff had.

People received co-ordinated care. We saw evidence in people's care plans that demonstrated people had been visited by their GP and other health care professionals. For example, people's files held information in relation to the advice sought from the speech and language therapist. People were visited by other professionals when there was a change in their needs and support plans were adjusted to reflect the advice that was given.

Staff demonstrated good knowledge of how they obtained consent from people on a day to day basis, when providing care and support. One person told us about how staff discussed things with them and helped them in making day to day decisions about their lifestyle. They told us, "The staff are smashing, they discuss everything with me."

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 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 saw that applications for DoLS had been made to the local authority for people who required this and authorisations were in place for nine people at the time of our inspection. We saw that provider audits were undertaken to make sure that the MCA and DoLS were being managed in line with current guidance. This included discussion with staff members to check they had the requisite knowledge.

People were involved in decisions about what they would like to eat and drink and encouraged to eat a healthy diet. We sat and chatted with people in the dining area at lunchtime and observed that most people had something different for lunch and for afters. People's comments included, "There's a menu and we choose from that.", "The food is good" and "There's lots of choice."

We observed that care staff and kitchen staff were aware of people's dietary preferences and aware of their individual and specific health needs, such as difficulty with swallowing and diabetes. We saw that people were provided with appropriate support to eat their meal and were encouraged to be as independent as possible. We did notice that some people sat at the table in their wheelchairs, which prevented them from getting near to the table, making it difficult for them to eat without spilling food. We discussed methods of rectifying this with the registered manager.

Staff had worked creatively to best use the inside and outside spaces to support people's independence and personal identity. There was a welcoming and friendly atmosphere and the communal areas had an assortment of decorations and objects to stimulate activity and engagement between people. Each person had their own bedroom, which could be individually personalised by bringing in personal items, such as ornaments and pictures, and we saw that people had been effectively supported to do this. This personalised their space and supported people to orientate themselves.

Is the service caring?

Our findings

Staff had built up positive relationships with people, we saw them chatting with each other, there were lots of smiles and laughing. People said that they liked the staff and felt well cared for. One person said, "I can't fault it at all." Another person told us, "I am very happy here. Staff are lovely and care for me very well indeed." One person's visitor told us that staff were caring and loving towards their friend, saying, "They love [person's name] to bits." One person said, "I have not been here long but already feel at home. Staff explain things and take a genuine interest in me."

The SOFI observation we carried out showed us there were positive interactions between the five people we observed and the staff who supported them. The staff showed patience, gave people lots of encouragement and had respectful and positive attitudes. They chatted with people and asked how they were and if they wanted or needed anything regularly.

People were involved in making choices about their care and we saw instances where information was provided in a way that was supportive of people with dementia and other communication needs. For instance, along with the written menu, there was a menu in picture form, which aided people's understanding, and encouraged their choice and involvement. Where people had difficulty choosing what they wanted, staff would show them different options to establish their preferences.

We saw that the staff treated people in a caring and respectful manner. People were clearly comfortable with the staff, they responded to staff interaction by smiling, laughing and chatting to them. When staff assisted people to mobilise using equipment, they explained what they were doing and why. They encouraged people's independence and respected their abilities. The atmosphere in the service was calm and relaxed.

There were no restrictions of when people were able to receive their guests and there were lots of visitors on the day of our inspection. In addition to this, one relative had become a volunteer at the home.

Each of the people we spoke with said they were treated with dignity and respect. The provider's commitment to upholding the values of privacy and dignity was noted in the information pack given to each person coming to live at the service.

Staff told us how they knocked on people's doors before entering and of the importance of keeping a person covered as much as possible while assisting them to wash. A staff member said, "Privacy and dignity should be a priority."

The premises maximised people's privacy and dignity as all bedrooms were for single use only; toilets and bathing facilities were provided with lockable doors. People were able to have a key to their own door, if they so wished, to enhance the privacy of their own room. Communal rooms and quiet lounges were available, as well as their bedrooms, for people to receive their guests.

Members of staff were aware of the principles of care. One member of care staff said, "I love my job, giving

people happiness gives me a great deal of satisfaction."

The service provided end of life care and there was a commitment to supporting people and their relatives, before and after death. People had end of life care plans in place, which clearly stated how they wanted to be supported during the end stages of their life. The provider told us the home was implementing the Gold Standard Framework in End of Life Care. The Gold Standards Framework is supported by many authoritative bodies and aims to provide the highest standard of care possible for people and their families. Relatives told us that the staff provided this care with compassion, and this extended to the support they provided to members of people's families and friends.

Is the service responsive?

Our findings

Before people moved into the home they and their families participated in an assessment of their needs to ensure the service was suitable for them. This included a life history document which contained information about their lives before coming to live at the home. Following this initial assessment, care plans were developed that provided guidance about how each person would like to receive their care and support and about their individual needs and risks. For example, people at risk of developing skin damage had skin integrity plans which described the actions staff should take to promote healthy skin. These included a repositioning regime and daily visual checks of skin most at risk of damage.

People's relatives told us they were welcomed into the home and were involved in their family member's reviews. People received personalised care which was responsive to their needs and their views were listened to and acted on. One person commented, "I am very happy here." One person's relative said about the service, "It really is a fantastic place." Another person who used the service told us, "It's excellent, I get what I want when I want it."

Of the eight care plans we looked at we saw that the majority were not reviewed and updated on a regular basis, to ensure the information in them was up-to-date. We saw two care plans which had last been reviewed in June 2016 and another which was last reviewed in March 2016. This was not in line with the monthly frequency expected by the provider. Other care plans had omissions such as; no life history completed, maintaining a safe environment document not completed and consent for information exchange document had not been signed by the person who used the service or by a staff member.

This is a breach of Regulation 17 (1) (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People at risk of poor nutrition had eating and drinking plans which described how they should be offered fortified diets. Care plans were in place in relation to reducing the risk of acquiring infections and safeguarding people from abuse. Breathing care plans were in place and included information about the signs and symptoms which might indicate a person was developing a chest infection. Staff told us that the care plans told them what they needed to know to manage people's care.

We saw that people spent time watching the television, reading newspapers and books and listening to music. One person was chatting on their phone and another using their laptop computer. People told us and we saw that there were plenty of activities on offer. There was an activities co-ordinator who devised and encouraged a number of different activities. This helped to keep people entertained and stimulated throughout the week. The activities schedules we saw included a number of different activities and entertainment events, which changed each week and took place at the home as well as trips out.

Staff told us that they always received an informative handover at the beginning of their shifts. They said these handovers were comprehensive and brought them up to date with people's needs and any concerns about people's health or well-being. One member of staff told us, "The handover is always done and is very

informative and up to date."

People were able to raise any concerns or issues they may have about the service. People told us, they would complain to the registered manager if they needed to." People's relatives also told us that they were familiar with how to make a complaint, or provide the service with feedback. One relative said, "I am always asked, and I tell them what I think." Staff members told us that people and their families were encouraged to give feedback, and we saw that information was on display around the home to help make sure people knew how to complain if they needed to.

The service had a complaints policy, which we were told was given to each person. There was also a record kept in the home of complaints and compliments received. The record showed that complaints were taken seriously, investigated and responded to, and apologies were offered where necessary. We also saw that a regular provider audit was undertaken to make sure that any complaints that had been received had been logged, investigated and resolved to an acceptable standard.

Is the service well-led?

Our findings

The Old Rectory had a registered manager who had been in post for a year and a half. The registered manager was supported in managing the service by a general manager and a quality manager. The provider also employed a trainer to provide in house training to staff.

Staff told us the registered manager had a consistent approach. One member of staff said that the registered manager provided any support they required to do their jobs. They told us, "The manager is always approachable for advice or guidance."

The provider had a quality assurance system in place, which included the registered manager and quality manager carrying out monitoring and checks on the quality of service people experienced. Accidents and incidents were also monitored by the registered manager to ensure any trends were identified, and appropriately recorded, including action taken to prevent recurrences. Following an incident at the home we found that although the provider and registered manager had implemented some action to prevent reoccurrence, they had not considered more immediate actions such as review of care records and risk assessments to ensure these were up to date and appropriate to keep people safe. We also found that moving and handling training for some staff was out of date and the provider had taken steps to arrange updated training for all staff following an incident. The registered manager told us that until all staff had received updated training they ensured those staff who's training was out of date would only work with another member of staff who had received up to date training. However at the time of the inspection we saw two staff who worked together to move people using hoists and slings, both staff training in moving and handling was out of date. Although we did not observe any concerns with their lifting technique, the action taken by the registered manager to ensure people were safe was ineffective.

We saw audits covered health and safety, food safety, medication, finance and the environment amongst other areas. This meant that the quality of service provision was monitored, although not in the frequency required to address issues in a timely manner. Regardless of previous identified issues, the last recorded audit for medication, including controlled drugs was in July 2016. Therefore, shortfalls identified at the last inspection had action taken to address them, such as those related to medication management, but improvements had not been sustained.

We saw that some issues highlighted in the audits were included in a plan of action, while others were not, making it difficult to monitor whether they had been addressed.

Some issues had been addressed quickly, but others had yet to be addressed. For instance, there was a need to refurbish some corridors, as the décor had sustained some day to day damage. This had been identified in the provider's environmental audit before the last inspection in April 2016, which stated that in particular skirting boards, handrails and some walls were in need of decoration. However, this task remained outstanding. In addition, at this inspection we noted that the carpet in the corridors was also beginning to look 'tired' and was damaged in some areas.

In addition, the systems in place had not picked some areas of concern we identified at this inspection, such as shortfalls in people's care plans and care records. The registered manager told us that no audits were carried out in respect of people's care plans and records.

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

We saw evidence that the home had regular meetings for staff groups including nursing, care, activities and cleaning staff. The notes of the meetings demonstrated that staff were asked for their views and ideas about how the service could improve. The minutes of these meetings were publically displayed so that visitors and people who used the service were aware of the discussions.

Staff told us that the service was a good place to work and that they enjoyed their job. They said that morale was generally good. One care worker said, "I like it here, I really enjoy it." Some staff felt that at times morale could be affected by the workload, but they generally felt that they worked well as a team.

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 12 HSCA RA Regulations 2014 Safe care and treatment
Diagnostic and screening procedures	Medication was not always adequately stored, administered or recorded.
Treatment of disease, disorder or injury	Regulation 12(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 17 HSCA RA Regulations 2014 Good governance
Diagnostic and screening procedures	The provider did not consistently maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user. Audits were not completed with the frequency required to address issues in a timely manner. Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Treatment of disease, disorder or injury	

The enforcement action we took:

Warning notice