Adiemus Care Limited

The Old Rectory

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?	Requires improvement
Is the service well-led?	Good

Overall summary

This focused inspection took place on 16 June 2015. This focused inspection was carried out to check that the provider had made the improvements required following our comprehensive inspection 7 October 2014 and our unannounced focused inspection on the 6 January 2015.

Following our previous comprehensive inspection in October 2014 and our focused inspection in January 2015, we asked the provider to take action to make improvements as we found evidence of major concerns at both inspections in relation to the quality and safety monitoring of the service. We were concerned about the high turnover of staff and found shortfalls in the availability at all times of suitably qualified and competent staff with the range of skills required in order to meet the needs of people. The provider was not meeting the requirements of the law as the service was not well led and the management of the service did not protect people against the risk of receiving care or treatment that was inappropriate or unsafe.

The Old Rectory is a residential care home which provides accommodation and personal care support and is registered for up to 60 people. On the day of our inspection there were 38 people living at the service.

Summary of findings

This report only covers our findings in relation to the previous breaches. You can read the reports from our comprehensive inspection carried out on 7 October 2014 and our last focused inspection 6 January 2015, by selecting the 'all reports' link for The Old Rectory' on our website at www.cqc.org.uk

At this unannounced, focused inspection 16 June 2015 we found that significant improvements had been made.

Since our last inspection of this service in January 2015 the registered manager has resigned. There was a new manager in post who told us they had submitted their application to register with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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.

All of the staff and relatives we spoke with were positive about the management of the service and said that the service had become more stable and the morale of the staff had improved.

In the main there were enough staff to support people to have their needs met. However, there was a potential risk of people not having their needs met in a timely manner if senior staff were not available to support at meal times and if sufficient staff were not available to respond to unforeseen events. Staffing hours to support people with access to planned activities had been increased but we were unable to judge the impact of this as those staff were not available on the day of our inspection.

Staff had been supported with access to regular supervision and opportunities to discuss their training and development needs.

People had their nutritional needs met and, where required, specialist advice and support had been accessed.

Staff were kind and caring. They demonstrated the right approach to the care and support of people and were attentive to their needs. People had their privacy and dignity respected and were relaxed and comfortable with staff.

The provider had systems in place to regularly monitor the quality and safety of the service.

The service was not consistent in planning to prevent and mitigate risks to people. For example, those people at risk of falls. Specialist support had not always been sought to provide advice and guidance to the service to safeguard people from the risk of harm.

Care plans described well the daily routines of people, but were sometimes lacking in guidance for staff in how to support people with planned strategies to safely de-escalate incidents of distressed reactions. Staff designated to work on the dementia unit had not always been provided with the support and guidance they needed to monitor and support people safely and effectively.

It was not always evident that people had been involved in the planning and review of their care. Where this would be beneficial for people living with dementia, information with regards to people's personal life histories was often left blank in their care plans.

Residents and relatives meetings had taken place which enabled and supported people to express their views about how the service was being run.

Summary of findings

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 consistently safe as risk assessment planning to prevent and mitigate risks to people at risk of falls was not always evident.

Staff had been trained in recognising abuse and were aware of how to report concerns.

Is the service effective?

Requires improvement

The service was not consistently effective as dementia training was ineffective in providing staff with the skills and knowledge they needed to support people who presented with distressed reactions to their environment or others.

Staff had been supported with access to regular supervision and opportunities to discuss their training and development needs.

People had their nutritional needs met and where required specialist advice and support had been accessed.

Is the service caring?

Good

The service was caring as the staff had the right approach to the care and support of people and were attentive to their needs.

People had their privacy and dignity respected and were relaxed and comfortable with staff.

Is the service responsive?

Requires improvement

The service was not consistently responsive as care plans were lacking in guidance for staff in how to support people with planned strategies to safely de-escalate incidents of distressed reactions. This meant that staff had not always been provided with the support and guidance they needed to monitor and support people safely and effectively.

It was not always evident that people had been involved in the planning and review of their care. We saw that although care plans had space to include people's personal life histories, these were often left blank.

Summary of findings

Residents and relatives meetings had supported people to express their views about how the service was being run.	
Is the service well-led? The service was well led and provided strong leadership and promoted a positive culture. The manager understood their roles and responsibilities. The provider had systems in place to regularly monitor the quality and safety of the service.	**Good** 

The Old Rectory

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.'

We carried out this focused unannounced inspection of The Old Rectory on the 16 June 2015.

The inspection team consisted of one inspector.

Before our inspection we reviewed the information we held about the service, this included the provider's action plan.

We spoke with the local authority safeguarding team and reviewed all other information sent to us from other stakeholders.

We spoke with four people who were able to verbally express their views about the service and three people's relatives. We observed how care and support was provided to people throughout the day. Including the midday meal provided on Redwood Unit, a unit designated to care for people living with dementia.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at care records in relation to four people. We spoke with nine members of staff, including care staff, senior care staff, domestic staff, the manager and the operations manager. We looked at records relating to staff training, staff rotas and systems for monitoring the quality and safety of the service.

Requires improvement

Is the service safe?

Our findings

At our previous comprehensive inspection of The Old Rectory on the 7 October 2014 and also our focused inspection 6 January 2015 we found that the provider had continued to fail to take action to ensure the availability at all times of suitably qualified and competent staff with the range of skills required in order to meet the needs of people using the service and to keep them safe at all times.

At this focused inspection we found that significant improvements had been made.

At our previous comprehensive inspection in October 2014 and also our focused inspection in January 2015 we found that there had been a high turnover of staff and, a high use of agency staff who lacked knowledge regarding the needs of people and morale of staff was low. Appropriate management delegation of staff was found to be lacking which meant that people were at risk of their needs not being met. The manager told us that the majority of vacant posts had now been filled and new staff appointed. The manager showed us staff rotas and explained how staff were allocated on each shift to each unit. Additional hours had been allocated and new staff employed to provide people with organised activities for six days per week.

People who could tell us their views said that there were enough staff to provide the support they needed throughout the day and night. One person told us, “There are enough staff about and they come quickly when you call.” Most of the staff we spoke with said there were enough staff to provide people with the support they needed and to keep people safe. However, two staff told us, “It can be a bit pushed at meal times.”. Other staff told us they thought there were enough staff employed in the home and told us, “I think the staffing levels are all right, it’s always busy at meal times and senior staff are not always available to help because they are giving out medicines or dealing with doctors.”

We observed the midday meal being served in one communal dining room. Three staff had been allocated to this unit. They told us that three people required support with eating their meals in their rooms and that these people received this support once all other people had been served and supported with their meals in the dining room. We observed an incident whereby one person became distressed and needed support from two staff for a significant period of time. This meant that people who required support with eating their meals in their rooms did not receive their meals until much later than planned as there were no additional staff available to support them. Our observations showed that there was a potential risk of people not having their needs met in a timely manner if senior staff are not available to support at meal times and sufficient staff available to respond to unforeseen events.

Staff told us they had received updated safeguarding training and we confirmed this with a review of the staff record of training attended. Newly employed staff told us they had received training in recognising and safeguarding people from the risk of abuse. Staff were knowledgeable and aware of how to respond to suspected acts of abuse and how to report concerns to their manager and relevant safeguarding authorities.

There were systems in place for reporting and recording accidents and incidents. Records showed us that the management team in the main took action to learn from such events and put measures in place which meant they were less likely to happen again. However, the provider’s recent compliance audits showed that the number of falls had been monitored but had identified a lack of action being taken in response to people who had regularly experienced falls and had been assessed as at high risk. This meant that planning to prevent and mitigate risks to people and action instigated, such as referral to falls prevention specialists, was not always evident.

A review of staff files showed us that the service had robust recruitment procedures in place. Staff files contained photographic identification, evidence of disclosure and barring service checks (DBS), references from the most recent employer and application forms. Newly appointed staff had received an induction when they commenced employed at the service. This included a period of shadowing more experienced staff, prior to working alone. Staff recently employed confirmed that this procedure had been followed. They also told us that the induction training they received helped to make them feel confident about their ability to carry out their role competently.

Requires improvement

Is the service effective?

Our findings

At our previous comprehensive inspection of The Old Rectory on the 7 October 2014 and also our focused inspection 6 January 2015 we found that staff did not always receive support with planned supervision to provide them with support and opportunities to plan their training and development needs.

We found at this focused inspection there had been improvements made.

Care staff told us that they now received regular supervision and staff meetings with their manager or a senior carer. These they told us provided staff with opportunities to discuss their care practice and plan their training and development needs. Records of supervision planning showed us that opportunities for staff to attend support meetings were planned and attended by staff.

The service had systems in place to record the training that staff had completed and to identify when training needed to be repeated. Each staff member had a file that recorded the training they had received. This meant that the manager could easily identify if staff had completed all the required training or needed to repeat a training course to keep up to date with safe practice.

Staff training records showed that all staff had completed a range of training relevant to their roles and responsibilities. This included training to keep people safe, such as in moving and handling, infection control, food hygiene and safeguarding people from the risk of abuse. In addition care staff had either completed or were undertaking a qualification in Health and Social Care.

All the staff we spoke with told us that they had completed training to make sure they had the skills and knowledge to provide the support individual people needed. One person said, “We do lots of training, including dementia. Although the dementia training tells you about different types of dementia it does not help you to know how to support people who might become agitated and distressed with you when you are trying to help them.” We discussed this with the manager and operations manager who told us they had recognised this as a shortfall, that they had recently sought support and had arranged for a competent person to meet with staff to provide additional training.

We looked at care records which showed that the principles of the Mental Capacity Act 2005 Code of Practice had been used when assessing an individual’s ability to make a particular decision. Staff told us they had received training in understanding their roles and responsibilities with regards to the Mental Capacity Act 2005 (MCA) and related Deprivation of Liberty Safeguards.

All of the people who were able to speak with us told us they were satisfied with the quality of meals provided. We saw that people being cared for in bed had their food and fluid intake monitored. People who had been assessed as at risk of inadequate nutritional intake had been referred to specialists such as dieticians for advice and support. Instructions given by dieticians to weigh weekly had been actioned. Management audits of people’s weights had highlighted where additional support was required and action plans produced in meeting people’s needs to receive adequate nutrition and hydration.

People had access to a range of health care professionals which included doctors, dieticians and community nurses in response to health concerns that had been identified. People who could speak with us told us that they received the support they required to see their doctor. One person said, “The staff get the doctor if I ask.”. Another person told us “They [the staff] ask for the doctor when I’m not well and I see the district nurse as well.”. Some people who lived in the service had more complex needs and we saw that they had access to specialist mental health services such as support from community psychiatric professionals.

Good

Is the service caring?

Our findings

We observed people in all of the communal areas of the service. We saw that people who could not speak with us were comfortable and relaxed with the staff who were supporting them.

Throughout our inspection we saw that people were treated with respect and in a caring and kind manner. The staff were friendly, patient and discreet when providing support to people. We saw that all the staff took the time to speak with people as they supported them. We observed many positive interactions and saw that these supported people's wellbeing. We saw a member of staff laughing and joking with one person and saw how this enhanced the individual's mood.

People told us that their privacy and dignity was maintained at all times. One person told us, "The staff make you feel comfortable when they help me to wash and dress. I have no concerns." Another told us, "They always knock on the door when they come to see me and I have never felt uncomfortable when they shower me. They talk to you throughout and reassure me."

We saw that staff communicated positively with people. Staff assumed that people had the ability to make their own decisions about their daily lives and gave people choices in a way that they could understand. They also gave people the time to express their wishes and respected the decisions they made.

Relatives told us that they were able to visit their relatives whenever they wanted. They said that there were no restrictions on the times they could visit. One person said, "We visit regularly and come at different times and it is never a problem."

Requires improvement

Is the service responsive?

Our findings

At our previous comprehensive inspection of The Old Rectory on the 7 October 2014 and also our focused inspection 6 January 2015 we found that people did not always receive care that was responsive to their needs.

Whilst we found some improvement at this focused inspection 16 June 2015, further work was required to ensure the provider was meeting the legal requirements.

Care plans, as well as guiding staff in how to support people with their personal care, advised staff as to people's desired daily routines. However, it was not evident that people had been involved in the planning and review of their care. We saw that although care plans had space to include people's personal life histories, these were often not completed or the information contained was limited. The gathering of this information is important in planning to support people's emotional and wellbeing needs particularly for people living with dementia. It is recognised good practice that the gathering of this information in planning to meet the needs of people would enable staff to aid reminiscence and plan steps to reduce anxiety as well as improve the well-being of individuals.

We observed a newly employed staff member attempting to support one person living with dementia who was presenting with an extreme distressed reaction to others. We saw that the staff member was struggling to cope with the situation and we asked the manager to attend to provide additional support. The staff member involved later told us they had not seen this person's care plan prior to being delegated to work on the dementia care unit. They also told us that, although they had received training in understanding different types of dementia, they had not received guidance or training in how to support this person in a way that was respectful and effective in promoting their safety and wellbeing. However, other staff had earlier noticed that this person showed signs that they were anxious and approached them quietly and asked if they would like to move to a different area where it was quieter.

We looked at this person's care plan and noted that their care plan recorded that they regularly presented with 'violent outbursts'. There was no guidance within the person's plan of care to guide staff in how to support this person with planned strategies to safely de-escalate incidents of distressed reactions, other than instructions recorded to, 'call the out of hours mental health crisis team'. This meant that staff had not been provided with the support and guidance they needed to monitor and support this person safely and effectively.

These shortfalls demonstrated a breach of Regulation 12 (1) (2)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us that there had been an increase in the number of staffing hours designated to provide people with a planned programme of organised social activities. They said that two staff had recently been employed to provide people with group and individual planned social activities with up to 42 hours over six days per week. However, on the day of our inspection none of the staff designated to these roles were working and no planned activities were provided to people other than their watching TV. This meant that we were unable to judge the impact of this addition of staff as the staff were not on duty and available during our inspection and none of the people we spoke with were able to tell us their experience of or recall involvement in any activities provided.

The provider had a formal procedure for receiving and handling concerns and complaints. Complaints could be made to the manager of the service or to the registered provider. This meant that people wishing to complain could raise their concerns with a senior person within the organisation. However, one complaint had not been responded to by the provider in a timely manner despite repeated requests by the complainant. This resulted in the person referring their complaint to the local authority who wrote to the provider requesting them to respond to the complainant. There was limited information provided to confirm that the complaint had been resolved. We discussed this with the manager and operations manager who were not clear what, if any, action had been taken in response to any failure identified by the complaint or able to explain the outcome of any investigation.

The Care Quality Commission had received one complaint about the service in the last twelve months. The concerns did not suggest that people who lived in the home were at risk and we passed the complaint to the registered provider to investigate. The provider responded to our request for information following their investigation which showed that they had investigated the concerns.

Requires improvement

Is the service responsive?

Residents and relatives meetings had been provided twice within the last six months. These opportunities enabled and supported people to express their views about how the service was being run.

Good

Is the service well-led?

Our findings

At our previous comprehensive inspection of The Old Rectory on the 7 October 2014 and also our focused inspection 6 January 2015 we found that the service was not well-led. We were not assured that the service was well-led with a culture of leadership that was open, transparent and reliable. This had placed people who used the service at risk of receiving inappropriate and unsafe care.

At this focused inspection we found that significant improvements had been made.

The previous manager had left their employment and a new manager had been employed since March 2015. The new manager told us they had submitted their application to register with the Care Quality Commission (CQC) and were waiting for notification of their fitness interview.

The service was well led and provided a strong and positive culture. All of the people, staff and relatives we spoke with were positive about the management of the service. Staff told us that staff morale had improved since the employment of the new manager. One member of staff told us, "The manager is superb. When you go to them with concerns they are dealt with promptly. The atmosphere here is much better, we now work well together as a team. Yes, a lot of staff have left but we now have a positive team who really care about people." Another told us, "This home has been through a difficult time but things are on the up." When asked by inspectors what had led to improved staff morale they told us, "The new manager is approachable, she really cares about people and it is a happier place to work. There has been a high turnover of staff but the negative staff have now gone and the staff we have now want to make things better for people who live here."

One relative told us, "The atmosphere has changed in the home. Staff are more relaxed, the new staff are friendly and the manager has a handle on things. We have noticed a real difference and feel things are much more settled."

It was evident from discussions with the new manager that they had full understanding of their roles and responsibilities. Discussions with both staff and the manager demonstrated a shared understanding of the key challenges to ensure continuous improvement of the service. The manager described how well they had been supported by their senior management team and described how regular audit and governance of the service had identified shortfalls and resulted in joint planning for continuous improvement of the service.

The provider had systems in place to regularly monitor the quality and safety of the service. For example, we saw records of management audits carried out to check the safety of bed rails, mattress checks, fire safety and medicines management checks. The provider's compliance teams visited the service regularly to carry out safety and monitoring checks of the service. Reports from these audits identified shortfalls and in the majority of these management actions required with timescales had been specified and actions completed. However, where shortfalls had been identified in the management of falls and action required to update and review people's care plans it was not always recorded what if any actions had been carried out to address these shortfalls.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (1) (2)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment **How the regulation was not being met:** Care and treatment was not always planned to mitigate the risks to people's safety and welfare.