Akari Care Limited

Felmingham Old Rectory

Inspection report

Aylsham Road
Felmingham
North Walsham
Norfolk
NR28 0LD

Tel: 01692 405889
Website: www.akaricare.co.uk

Date of inspection visit: 06 and 07 October 2015
Date of publication: 25/11/2015

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This inspection took place on 06 and 07 October 2015 and was unannounced.

Felmingham Old Rectory provides accommodation and care for up to 41 people. At the time of our inspection 30 people were living in the home. Many of these people were living with dementia and few could tell us verbally about their experiences of living in the home.

A registered manager was 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.

Summary of findings

This inspection identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches related to cleanliness and infection control concerns and the governance of the service.

People's rooms and ensuite facilities were not always clean. We found several rooms that required attention despite two or three housekeeping staff being on duty during the two days of our inspection. Poor monitoring of the service meant that these concerns were not acted upon, even though they had been identified during the last infection control audit.

Due to poor communication some staff were not aware of the extent of their accountability or responsibility for certain tasks which lead to these tasks not being carried out effectively or not being carried out at all. The manager had not ensured that tasks that had been delegated to other staff had been carried out. Training and support had not been provided to the activities co-ordinator which resulted in people not receiving adequate social support.

You can see what action we told the provider to take at the back of the full version of the report.

The environment, both internally and externally, was not conducive or stimulating to people living with dementia.

There were enough staff on duty to meet people's needs. Staff underwent a robust recruitment process to ensure the risks of employing unsuitable staff were minimised.

People had good access to a range of healthcare professionals. Staff were quick to identify if someone was unwell and sought advice and support promptly. They implemented instructions from healthcare professionals in a timely manner to ensure people received the support they needed.

Staff were kind and friendly but did not always act promptly to support people's dignity by ensuring their clothes were clean. They knew the people they supported well and were able to speak with us about people's needs and preferences in detail.

Improvements were required to ensure that the service sought and acted upon the views of people's relatives and staff in how the service provided care and support for people. This was particularly important because most people living in the home were unable to communicate in any detail about their wishes or preferences.

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.

People's rooms were not kept clean which was an unpleasant environment for them and put them at risk of infection.

There were sufficient numbers of staff deployed throughout the home to meet people's needs.

People's medicines were stored and administered to them safely.

Is the service effective?

Requires improvement

The service was not consistently effective.

Adequate training and support had not been provided to the staff member responsible for providing activities and social stimulation for people.

The internal and external environments were not conducive to people living with dementia.

People's fluid intake was poorly recorded.

People had good access to support from health professionals.

Is the service caring?

Requires improvement

The service was not consistently caring.

Whilst staff were patient and treated people kindly they did not always notice when people required support to maintain their dignity.

People's relatives were not routinely involved in helping to plan people's care, but a system was due to be implemented which would address this.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

Staff responded promptly to ensure that people's health needs were met.

People's social needs had not been adequately planned for.

People's relatives were kept informed in relation to their family member's welfare and complaints were handled appropriately. However, communications with people's families and visitors needed to improve in order to obtain their feedback on the service.

Is the service well-led?

Requires improvement

The service was not consistently well led.

Poor communication within the service led to staff not understanding what was expected of them on occasion.

Summary of findings

The views of people's relatives and staff were not obtained frequently enough to help the service improve and develop an inclusive culture.

Where areas for improvement had been identified, actions had not been taken or improvements were not sustained.

Felmingham 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.

This inspection took place on 06 and 07 October 2015 and was unannounced. It was carried out by three inspectors.

Before visiting the home we reviewed information we held about the home and notifications of incidents. A notification is information about important events which the service is required to send us by law.

During this inspection we spoke with four people living in the home, relatives of four people, three visiting healthcare professionals, the registered manager, one deputy manager, five care staff, an activities co-ordinator and a kitchen assistant. We observed care and support being provided to people living in the home on both days of our inspection.

We looked at the care plans of five people including medication records and at various records relating to the management of the service.

Requires improvement

Is the service safe?

Our findings

In August 2015 an audit had been carried out by the Public Health infection prevention and control team. They found that there was no dirty to clean work flow and no handwashing sink in the laundry. A deep sink was being used to clean dirty commodes and to empty and fill housekeeping buckets in the laundry. These arrangements posed a risk of cross contamination to clean laundry. The head housekeeper and a member of their staff told us how they were not now using the deep sink for commode and bucket cleaning. The manager told us the audit was with their head office for consideration in relation to improving the laundry and creating a designated sluice room and that the provider was happy to invest money where necessary. The provider had told us in 2013 that a refurbishment of the premises would include a new laundry. This had not happened.

People were at risk of acquiring infections because effective systems were not in place to ensure that cleanliness and hygiene standards were met. We found that the laundry was accessed via an unclean room and corridor. The flooring in this area and the laundry was either concrete or ripped linoleum, neither of which could be effectively cleaned.

One relative told us, "Care comes first rather than cleaning." Whilst communal areas were clean, many people's rooms were not. Several people's bedrooms smelt strongly, as did one corridor. We noted dirty sink surrounds in people's en-suites. Some en-suites had carpets which were difficult to clean and could harbour germs. One person's bedroom carpet had faeces on it on both days of our inspection. The sink units in several people's rooms were missing edging strips so grime and soap scum had accumulated on the rough edges. Two people's beds had been made but the bed linen was soiled. Some bedrooms clearly hadn't been vacuumed for days. Three toilets were badly stained below the water line. Some en-suite bathrooms had dirty pull cords. In some cases this was because the pull cords had no fitting at the bottom for people to hold in order to turn the light on or off. A crust had formed inside a plastic jug in one person's room just above the level of the drink inside. Several wheelchairs had dried food particles on them.

These findings constituted a breach of Regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff understood and described to us potential signs of abuse. We were told that senior staff would be responsible for reporting any concerns to the local authority.

We saw that people's care plans included risk assessments and guidance for staff on how to reduce risks to individuals. The risk assessments covered areas such as personal care, mobility, pressure care, falls and nutrition. We also noted risks specific to individuals based on how they chose to spend their time. For example, one person liked to spend time in the grounds doing odd jobs and gardening. A risk assessment was in place for these activities.

During our inspection we saw that there were enough staff to provide people with the care and support they needed and that staff were effectively deployed within the home. People did not have to wait for long if they required assistance. The communal areas and bedrooms were mainly on the ground floor. However, the three lounges were some distance from each other but we found that staff were on hand in each lounge to help ensure people's safety and welfare.

The manager told us that staffing levels were determined with the assistance of a dependency tool. Agency staff would be used if necessary but the manager preferred to avoid this as far as possible because agency staff did not have the familiarity with the people that established staff did. The two deputy managers shared the on call duties between them, which meant that they were on call for seven out of every fourteen days. The manager told us that they could be called out for emergencies such as injuries or hospital admissions, but said that they had confidence that their deputy managers were able to manage these situations.

The provider had systems in place to reduce the risks of employing unsuitable staff. Staff recruitment files we reviewed included application forms, references, proof of identity and Disclosure and Barring Service checks.

People's medicines were managed by a small staff group, mainly the two deputy managers and a few senior care staff including some night staff. Where people were prescribed medicines on an 'as required' basis there was written guidance to ensure people were given their medicines appropriately. The medicines were stored in a suitable lockable cabinet and the treatment room and its contents were well organised. People received their medicines when they needed them and at the required times. We saw that

Requires improvement

Is the service safe?

staff took time to administer medicines to people in a caring manner without rushing. The manager told us that staff who administered medicines to people had their competency to do so assessed on an annual basis. However, they could only provide us with a competency assessment for one staff member that had been carried out in 2014

Requires improvement

Is the service effective?

Our findings

Care staff told us that they undertook training in a wide variety of topics which included managing behaviour that challenged and dementia. They told us that they had gone through an induction process and received ongoing supervisions and appraisals from either the deputy managers or the manager. They were positive about the standard of training they received and said that senior staff were able to provide further guidance and support as necessary. Most care staff had social care qualifications. The manager told us that they had recently received their training in the Care Certificate and that this would be implemented in the home soon.

A staff member who was supporting people with activities told us they had not received training in order to help them support people living with dementia with their social or emotional wellbeing. They told us that they found it difficult to get people to participate in activities and that many people preferred to sleep. They also told us they had not received any supervisions. They said that as well as doing activities with individuals they spent time cleaning and cutting people's fingernails, assisting with meals and general tasks. These factors contributed to people not receiving the social stimulation they required to help motivate them to interact with others and have purpose in their days.

The external environment wasn't conducive to people living with dementia. Whilst the grounds were extensive they were mainly grassed. There were no paths for people using wheelchairs to access and few paved areas that people could use to sit outside in good weather. Most people's rooms were on the ground floor and most of these looked out onto areas covered in weeds, some of which were waist high. The view from one person's room was a tall bush covered in brambles that severely restricted the amount of light entering their room. The dining room looked out on to an area covered in nettles and thistles.

A relative told us they would like to see decoration on the walls and music that was relevant to people living in the home. The internal environment provided little visual stimulation for people other than the television. They had nothing to look at, touch, smell or interact with. Chairs in lounges were all placed around the edges and people had nowhere to put anything. We saw people trying to balance drinks on chair arms. We pointed this out to the manager who told us that there were a lot of tables in people's rooms and she would have some of these relocated to the lounges.

The Care Quality Commission (CQC) is required by law to monitor the Mental Capacity Act (MCA) 2005, Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The MCA aims to protect the human rights of people who may lack the mental capacity to make decisions for themselves. The DoLS are part of the MCA and aim to protect people who may need to be deprived of their liberty, in their best interests, to deliver essential care and treatment, when there is no less restrictive way of doing so. Any deprivation of liberty must be authorised by the local authority for it to be lawful.

The manager told us they had submitted six applications to the local authority to restrict people's liberty to keep them safe, but that they had another 20 applications to do. They told us they expected to have these 20 applications completed within days.

Mental capacity assessments were in place in relation to people's day to day care. We also noted that an assessment had been carried out to determine whether one person was able to make decisions relating to their future care requirements and that subsequent decisions had been determined in their best interests with involvement from appropriate health professionals and family. However, we also saw a document called 'permission to take photos (unable to consent)'. Staff had determined that it was in the person's best interests for their photograph to be taken for the purposes of inclusion in a newsletter or activity board and to identify wounds. This person's next of kin had not been consulted about this. The service had not actred in accordance with the MCA when this best interests decision had been made.

We observed that staff asked people's permission before providing them with any care or support. For example, people were asked their permission before staff assisted them to move to another room, whether they wanted help with cutting their food up into smaller pieces or whether they would like their nails done.

At lunchtime people were brought plated up choices of the meals on offer so they could make their choice and receive it at the same time. The lunchtime meals looked and smelt appetising. There was also a menu board on each dining

Requires improvement

Is the service effective?

table showing pictures of what was on offer. There was a trolley mid-morning and mid-afternoon where people could choose from biscuits, fruit, cakes and various drinks depending on the time of day. However, on several occasions we saw staff take a biscuit tin to people, select a biscuit for them and offer it to them by hand. People were not given the opportunity to choose for themselves.

Information regarding food allergies, cultural requirements and special dietary requirements were gathered upon admission, reviewed weekly or when people's needs changed and available to kitchen staff. The kitchen assistant told us that people living in the home at present did not have any cultural dietary requirements, but these could be accommodated as necessary.

At the time of our inspection eleven people were having their fluid intake monitored and recorded on fluid charts. We noticed that fluid was usually recorded in increments of 200 millilitres (mls) only. Throughout our two day inspection we monitored the records of one person who required full staff assistance to drink. At one point the records showed that they had drunk 400 mls in one sitting, although the levels of squash in their jug and beaker suggested that 50mls had been consumed. The deputy manager spoke with a staff member who had advised that they had topped up the person's squash jug. The fluid records for this person varied considerably. Sometimes nothing was recorded after mid-afternoon and daily totals varied between 500 mls to 2900 mls. The deputy manager said they would review and monitor this person's fluid consumption and recording closely to ensure their needs were met. They thought that most of the eleven people did not need their fluid levels recorded any longer and told us they would review the necessity of this on an individual basis.

People had good access to health professionals. We spoke with a visiting community nurse who was familiar with the service. They told us that staff made appropriate referrals to the community nursing team and followed instructions and guidance well. This view was shared by a visiting GP we spoke with. The community nurse told us that staff would seek their advice when they visited. For example, on one occasion they had asked the nurse to look at a person who had developed a skin rash. People's records showed that they had access to wide range of health professionals including the falls team, chiropodists and the dementia intensive support team. Where concerns were raised we could see the progress of any investigations until the concern had been resolved and people received the necessary treatment and support.

Requires improvement

Is the service caring?

Our findings

One person told us, "I'm fine thank you. Staff are very kind." A relative told us, "Staff talk with us about [family member] with respect and consideration. They treat [family member] as an individual. The deputy manager [staff member's name] is amazing." Another relative told us that staff were kind to people and answered any questions they had. A third relative told us, "Staff are really kind and welcoming. They allow [family member] to be who they are and that [family member] is noticed as an individual."

Staff were patient and took time to speak with people in a friendly, unhurried manner. They knew the people they cared for well as they spoke with them about things of interest or relevance to them. When people were unable or chose not to respond staff observed their physical response to interpret how the person was feeling or their opinion about something. They understood the concerns, behaviours and preferences of the people they were supporting which helped staff to deliver people's care in a way that would be well received. A staff member described how one person scrunched their face up when they were uncomfortable or unhappy about something.

We observed two staff members assisting one person to move from a chair to a wheelchair using a hoist. They spoke with the person calmly and explained what they were doing at each step and smiled re-assuringly. The person did not exhibit any signs of being distressed. Staff then spoke with the person regarding what their choices were for lunch to which the person nodded and indicated their preference.

Staff did not always notice when people required assistance to maintain their dignity. One relative told us that their family member wasn't always dressed in clean clothes when they visited. We observed that one person had spilt their drink down them during the morning. They were not assisted to change their clothes until after lunch. We saw that another person had scratched a sore area on their face and blood was flowing down their face and was over their hands. However, until we pointed this out staff hadn't seen this but they dealt with it in a kind and dignified manner.

People living in the home would not have been able to participate in the planning of their care in any detail. One relative told us that whilst they had been involved in their family member's assessment prior to them moving in to the home, they had not been involved in any subsequent reviews of their care. The manager told us they were about to implement a 'resident of the day' review programme. This is a system that reviews each person's care and support on a given day. A plan for the 'resident of the day' system showed that people's relatives were to be contacted to discuss and obtain their views on the care their family member received.

People's records were not stored securely so people's information was not kept confidential. The room where people's care records were kept was in a central area of the home. This was often left unsecured and we saw people wandering in and out. When we went to sign out of the premises on one of our inspection days the signing in book had disappeared. A staff member told us that one person tended to take it. The unsecured room meant that there was a risk that sensitive information relating to people living in the home could also be misplaced.

Requires improvement

Is the service responsive?

Our findings

The service had good information about people's life histories and preferences. However, this information was not often used to support people with maintaining or developing hobbies or interests. One person had worked in horticulture before they moved into the home and they were happy to spend most of their days outside in the garden when the weather was good. However, they were not supported to do anything purposeful in the garden, but were left to their own devices with staff checking on them periodically to ensure their safety. A few people were able to play games and do puzzles with staff but people unable to do this tended to spend most of their time asleep.

People's needs were assessed prior to them moving in to the home. Detailed care plans and risk assessments were in place to help guide staff on how to maintain people's safety and physical wellbeing. These were individual for people, reviewed regularly and updated as necessary. We noted that if people had health conditions that staff needed to be mindful of, specific care plans were in place. For example, one person was living with an intestinal condition that was clearly documented and guidance was provided for staff showing what they needed to check for to make sure the person's health was maintained.

Relatives told us that staff informed them promptly of any concerns, for example if the GP had been called or their family member had had a fall. Records we reviewed confirmed this. We spoke with two community nurses who were positive about the way staff responded to people's welfare needs. One told us that staff were adept at administering first aid and that their recording of wound sites was very good. The other said that staff knew the people well and were quick to act on any changes and the staff worked well with them to improve people's health and implement preventative measures to help ensure their well-being.

The provider's complaints process was available to visitors to the home in the main reception area. People's relatives told us they would be happy to raise concerns with the manager, their deputies or their family member's key worker. One relative told us that the manager always made time to speak with them and acted on any concerns if they had any. Another relative told us, "I can't find any fault with them here. There's nothing to complain about." The manager told us that they had received one complaint in the previous 12 months. This been acted upon promptly.

Improvements were required in the way that the service sought the views of people's relatives and other visitors. This was particularly important as people living in the home were often unable to contribute their views in any detail. We reviewed the minutes from a resident and relatives meeting held in May 2015. One relative told us that they were unaware that there were resident and relative meetings and had last received a survey requesting their views two to three years ago. Another relative told us that they attended meetings at the home but they had not seen any minutes from these meetings or any action plans to show what changes or improvements were planned as a result.

Requires improvement

Is the service well-led?

Our findings

There is a registered manager in place. The manager told us that they were well supported by the provider. The provider had a comprehensive auditing system in place which included the provider's representative carrying out a monthly quality audit as well as those the manager carried out on a monthly basis. The manager's September 2015 infection control audit had identified several areas as 'not achieved' in relation to people's rooms. We had found considerable infection control issues during our inspection, particularly with regards to people's rooms. This audit had been ineffective because corrective actions had not been implemented or sustained.

Staff supported each other, but a lack of clear communication had led to misunderstandings which resulted in tasks being missed or not completed satisfactorily. Tasks the manager had thought were delegated to other staff hadn't been carried out or were done ineffectively. For example, the manager told us that the deputy managers were responsible for checking and signing off fluid charts. When we spoke with a deputy manager they told us they didn't know they were required to do this and that fluid charts were not checked or signed off by them. The head housekeeper told us they had been asked to check the standard of the cleaning. However, they said they didn't know what had been meant by this and just asked other housekeeping staff if they had completed certain tasks they had been given. These areas had not been monitored to ensure that these tasks had been completed satisfactorily.

A survey carried out in March 2015 showed that two out of five staff members were not sure that their views would be listened to, but this had not been identified as requiring any action to address this perception. Minutes from meetings we were given showed that the last staff and seniors meetings took place in February 2015. Better communication was needed within the service to ensure that staff felt their views and suggestions were welcomed.

Accident and incident analysis was taking place but key information to identify patterns was not being gathered. For example, the analysis did not detail where the accident took place or which person was involved. This would indicate which people were more likely to experience accidents or incidents or any parts of the home that could present a risk to people. Without this information it would be difficult to identify whether changes could be made to help prevent future re-occurrences.

The March survey had identified activity provision as an area for improvement. The action point from this was that the manager would ensure that the new activities co-ordinator would have guidance and support. This had not happened. The environment, both internally and externally, was also not stimulating for people. As a result people were not always receiving adequate support with their social needs. The only other action point from this survey was to ensure that a variety of snacks were available from the trolley. During our inspection we saw that people were offered biscuits which they hadn't had the opportunity to choose for themselves. Whilst the survey had been evaluated it had not resulted in an improved service for people.

People's care records were not kept confidential. They were accessible to anyone living in or visiting the home.

These findings constituted a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us the manager was approachable and supportive. We saw that the manager welcomed people living in the home into her office. During our inspection we saw that people frequently went into their office for a chat or to ask questions. Visitors were also welcomed.

The last resident and relative meeting had taken place in May 2015. The minutes from this meeting showed that relatives who attended were supportive of the home. Whilst the service was good at keeping relatives informed regarding their family member's well-being, more needed to be done to involve them in planning their family member's care and encourage their views to inform the way the service was run and developed. Without good relative and visitor input the service was at risk of providing a service that did not take account of feedback to improve because most people living in the home were unable to communicate their views in detail.

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
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way because people who use services were not protected against the risks associated with the spread of infection. Regulation 12(1)(2)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Adequate systems were not in place to identify risks to people's welfare or improvements required to the service. Where they were in place, action was not always taken to make the necessary improvements. People's records were not secured. Regulation 17(1)(2)(a)(b)(c)(e)(f)