The Old Rectory Residential Home Limited

The Old Rectory

Inspection report

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Breaston
Derby
Derbyshire
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Tel: 01332874342

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13 March 2017

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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?	**Inadequate**

Summary of findings

Overall summary

This inspection was unannounced and took place on 13 March 2017. The service was registered to provide accommodation for up to 26 people. People who used the service had physical health needs and/or were living with dementia. At the time of our inspection, 14 people were using the service.

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

This location had a previous inspection when it was under a different named provider. However, the new provider was the same person as before, and the registered manager and staff remained the same. We have therefore referred to the previous inspection within this report.

Risks to people were not consistently assessed, monitored and reviewed. When people were not able to make decisions for themselves, the provider had not shown how their care and support was provided in their best interests. Staff were not always supported effectively to ensure they had the knowledge and skills to carry out their roles. People were not always supported to maintain a balanced diet and had limited choices for their meals.

People did not always receive care that was personal to them. People did not have the opportunity to participate in activities that interested them or provided stimulation. People's care records were not always reflective of their individual needs. Not everyone knew how to raise concerns and complaints.

The provider was not meeting their registration requirements, as they had not informed us about specific incidents that had occurred. They did not have effective systems in place to monitor the quality of the service or to drive continuous improvement. The provider did not actively encourage people to contribute to the development of the service.

Staff understood their responsibilities to protect people from harm. There were enough staff to meet people's needs and the provider checked staffs suitability to work with people. People received their medicines as prescribed and had access health care services.

Staff were caring in their manner and knew how to promote people's dignity. They helped people to be independent and respected the day to day choices people made. There was a registered manager in post and staff were positive about working for the provider.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risks to people were not always assessed, monitored and reviewed. Staff understood their responsibilities to protect people from harm. There were enough staff to meet people's needs and the provider checked staffs suitability to work with people. People received their medicines as prescribed and these were stored securely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

When people were not able to make decisions for themselves, the provider had not shown how their care and support was provided in their best interests. Staff were not always supported effectively to ensure they had the knowledge and skills to carry out their roles. People were not always supported to maintain a balanced diet and had limited choices for their meals. People had access to health care services.

Is the service caring?

Good

The service was caring.

Staff were caring in their manner and knew how to promote people's dignity. They helped people to be independent and respected the day to day choices people made.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive care that was personal to them. People did not have the opportunity to participate in activities that interested them or provided stimulation. People's care records were not always reflective of their individual needs. Not everyone knew how to raise concerns and complaints.

Is the service well-led?

Inadequate

The service was not well led.

The provider was not meeting their registration requirements, as they had not informed us about specific incidents that had occurred. There were not effective systems in place to monitor the quality of the service and to drive continuous improvement. The provider did not actively encourage people to contribute to the development of the service. There was a registered manager in post and staff were positive about working for the provider.

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.

This inspection visit took place on 13 March 2017 and was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We checked the information we held about the service and the provider. This included notifications that the provider had sent to us about incidents at the service and information we had received from the public. We also received feedback from the local authority who provided us with current monitoring information. We used this information to formulate our inspection plan.

On this occasion, we had not asked the provider to send us a provider Information return (PIR). A PIR is a form that asks the provider to give some key information about the service. This includes what the service does well and improvements they plan to make. However, we offered the provider the opportunity to share information they felt was relevant.

We spoke with nine people who used the service, two relatives and two visiting professionals. We also spoke with three members of care staff, the registered manager and the provider. Some people were unable to tell us their experience of their life in the home, so we observed how the staff interacted with people in communal areas.

We looked at the care plans of four people to see if they were accurate and up to date. The provider sent us information showing us how staff were recruited and we checked the training records to see how staff were trained and supported to deliver care appropriate to meet each person's needs. We also looked at records that related to the management of the service including the systems the provider had in place to ensure the quality of the service was continuously monitored and reviewed to drive improvement.

Requires Improvement

Is the service safe?

Our findings

Risks to people were not consistently managed. For example, some people were at risk of falls. We found there were delays in referrals being made to community professionals when people had fallen. For example, one person had fallen seven times and after the first five falls, the records stated that 'no action' had been taken and the provider had not identified that any action was required. We saw that three other people had been involved in accidents, and even though these were usually recorded, no actions had been identified to minimise the risks for these people in the future. Risks to people during the night were not assessed. It was recorded that one person would frequently walk around the home during the night. The provider was not seen to have considered any possible risks for this person, and information to give guidance to staff when this happened was not included within their support plan. The provider had not considered the potential risks of people who used the service going into other people's bedrooms. One person told us, "A resident has come into my room twice; it affects my peace of mind." Another person said, "Some residents come into my room and they have taken things. I should get a key really. I told the staff and they said I need to see the manager, but I don't see them that often." This meant we could not be confident that these risks were managed effectively.

These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that some people could become anxious; however, there was no guidance for staff to follow in these situations. One staff member told us, "Some residents shout at the others, and can sometimes be aggressive when we are helping them with their personal care. Others can get annoyed with each other at times by [what they are doing]." We asked how they knew how to support people if this should happen, and the staff member said, "We get to know the residents; sometimes we may need to take people into a different room to get them to calm down." This meant we could not be sure that people were supported in a consistent way if they became upset.

People felt safe receiving support from the staff. One person told us, "I have felt safe every day." Another person said, "Having staff here all the while makes me feel safe." Staff understood their responsibilities to keep people safe and knew how to report any concerns. One staff member commented, "If people were cruel to the residents, that would be abuse, and I would report it to the manager and write down my concerns. I would also be able to report to the local authority or you. We are asked to report things." Staff were aware of the whistle blowing policy. This is a policy that protects staff if they report poor practice, anonymously if they chose. One staff member told us, "I would use this if I needed to."

On the day of our visit, we found there were sufficient numbers of staff to meet people's needs. One person told us, "I think there are enough staff." Another person said, "There are just enough staff." When people requested support, they did not have to wait for the staff to help them. One person commented, "The staff come quickly, they are pretty good all of them." Another person told us, "They usually come quick when you want them." We saw the provider used a dependency tool to determine how many staff were needed; this was based on people's care needs not only on the number of people living there.

We checked to see how staff were recruited. One member of staff told us, "I had to submit my references and have a DBS check before I could start working." The disclosure and barring service (DBS) provides checks on people, to enable employers make safer recruitment decisions. The provider sent us information showing that they completed the necessary checks to ensure that staff were recruited safely.

People received their medicines as prescribed. One person said, "The staff help me with my tablets; I can't remember all of them, and they make sure I have them each day." We saw that people's medicines were stored securely so that only authorised people could have access to them. When people had their medicines, staff would record this on the administration sheets. These records were up to date and completed fully. Some people who were unable to understand why they needed to take their medicines could be reluctant to take them as prescribed. We saw that when this happened, agreement had been given by the doctor to administer these covertly (for example, hidden in their food). Staff told us they could not administer people's medicines until they had received training to do this, and that the pharmacy tested their understanding to do this correctly.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection, we found the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was not working within the principles of the Mental Capacity Act 2005 (MCA). The MCA provides the 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 capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. At this inspection, we found that some improvements had been made, but further improvements were required.

The registered manager told us that the majority of people were not able to make decisions about their care and support. The provider had not assessed people's capacity to make specific decisions and was not able to evidence how to ensure the support they received was in their best interests. The provider had determined that some people were not able to make decisions about their medicines. However, once this had been assessed, the provider had not then shown how support should be provided to ensure this was done in people's best interests. This meant that the provider was still not acting in accordance with the MCA and the associated code of practice. We were also not confident that the staff we spoke with were familiar with the principles of the MCA. For example, one staff member thought this was only in relation to do not attempt cardio resuscitation orders. Another staff member told us, "We are waiting for social services to do their care plan with the capacity assessment." This demonstrated that the provider still did not show a full understanding about their responsibilities to act within the guidance of the MCA.

This was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Deprivation of Liberty Safeguards (DoLS).We checked whether the provider was working within the principles of the MCA, and whether any conditions are authorisations to deprive a person of their liberty were being met. We saw that one authorisation had been granted and the provider was aware of the conditions that they had to meet. We also saw that other applications had been made to the local authority.

Not all staff had received the mandatory training they needed to ensure they followed safe working practices. For example, one member of staff told us they had not received any moving and handling training. Even though the people who used the service on the day of our visit did not need to use equipment to help them transfer, there had been occasions when people had fallen. When this had happened, the staff should have been trained to know what to do in these situations. This also meant that staff would not have been trained to safely support anyone new coming into the home who needed help with transfers.

Staff received an induction when they started working in the home. One staff member told us, "I was shown round and introduced to people. I then completed some first aid training. I also spent some time shadowing

the other staff." However, we were not confident that all the staff were supported to carry out their roles effectively. For example, one staff member told us, "I feel I need more training; and after my induction there were no competency checks or meetings about my probation." This meant the provider had not ensured that staff were able to support people on their own.

We checked to see how people were supported to have enough to drink and eat. One relative told us, "Since my relation has been here I have had concerns around the levels of fluids they have and the availability of drinks." We saw that one person was prone to contracting urinary tract infections. When this is a risk for people, it is important that they have enough to drink during the day. We saw that they had been assessed as not being aware of how much fluid they consumed. The provider had not put a system in place to monitor their drinks. This meant that staff would not know if this person had drunk enough during the day.

Some people were at risk of losing weight. We saw that records were kept to monitor people's weights. However, there was no evidence that actions had been taken after one person had lost a considerable amount of weight over a five week period. We discussed this with the provider and they were not able to show us how this concern had been followed up. Some staff we spoke with were not aware of people's specific dietary needs. For example, if people were diabetic. This meant we were not confident that people's nutritional needs were met and any risks were managed effectively.

People enjoyed the food. One person told us, "The food is hot and tasty." Another person said, "I like the food; it's varied and you have fruit and greens. I'm happy with the food." However, it was not clear how people were involved in the menu planning and how people were offered choices. One person commented, "We don't get a choice of meals." Another person told us, "They do offer an alternative if we don't like the hot lunch that's offered." Other people gave us examples of food they would like to have eaten, but that these options were not included in the menu.

People were supported to maintain their health. One person told us, "The doctor comes very quickly when you need them." One relative said, "There were concerns about my relations health, and the GP was called out." A community professional commented, "They are very good the majority of the time and issues are dealt with promptly. The staff will escalate any concerns to us." We saw that when concerns were raised about people's health the doctor had attended as requested.

Good

Is the service caring?

Our findings

People were positive about the care they received from the staff. One person said, "The staff are good and kind." Another person told us, "The staff are patient with me." They added, "The staff accompanied me to the hospital; and no one has cared for me like they did." One relative commented, "The staff are very pleasant, all of them." Another relative said, "The staff respect my relation and their needs." Staff understood that people should not be discriminated against, and people were encouraged to express their individuality.

We observed staff speaking with people in a respectful and dignified manner. When people were asked if they needed support with their personal care, this was done in a discreet manner. People told us that the staff would knock on their bedroom doors before entering and would ensure that their dignity was maintained when they were being supported. Staff would adjust people's clothing to ensure they were covered up. We saw that people's information was kept securely to protect their privacy and rights to confidentiality.

Staff encouraged people to maintain their independence within the home. One staff member told us, "It is important that people can do what they can for themselves. Even if it is small things like choosing the clothes they want to wear." Some people liked to help with the cleaning and we saw they were given a cloth to do this with. We observed people making choices about where they would like to sit and staff respected these decisions. People were able to walk around the home and staff did not try to prevent this from happening.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection, we found the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured that people received individualised care that reflected their personal preferences. At this inspection, we found that the required improvements had not been made.

We found there was still a lack of stimulating activities for people to participate in. One person told us, "We do very few activities, I just read at the moment. It would be nice to go into the village. We did go shopping once, but I would like to be able to get out more. The staff are always busy; they have a lot to do." Another person said, "I would like to go out for a walk; I have asked a lot of times but nothing has ever come of it. I'd also like to go to the pub but have never been offered." A third person commented, "There are no activities; not much at all. The staff spend time with me sometimes, but not often as they are busy." One relative told us, "There is no stimulation for the people who live here; most of the time there is nothing going on." One staff member we spoke with agreed that a more co-ordinated approach to activities would help the people who used the service. They said, "There is not a lot going on, and it would be good if we could take people out more." Another staff member told us, "We do try to fit some things in the hour between supporting people with their care. There is some entertainment arranged such as the organist who comes in each fortnight." We saw that people did not have access to any resources or have items of interest near to them that they may have liked to use. This meant that people were not supported to follow their interests.

At our previous inspection, we asked the provider to make improvements to ensure that people's care records reflected their individual needs and preferences. This would have enabled staff to understand people better and give them clear guidance as to how people should have been supported. At this inspection, we found that some people's care records still required further improvements. For example, one person could get quite distressed, and their care plan did not give staff information as to how they should have supported them when this happened. Staff told us they would refer to the care plans to ensure they supported people in the correct way. However, as this information was not there, we could not be sure that the staff would support people in a consistent manner and as agreed. Another person's care records stated that they would sometimes have medicines if they were anxious or distressed. However, the registered manager told us that they no longer had this medicine prescribed. The care records had not been updated to reflect this change, which could have led to confusion for the staff supporting them.

We saw that some care plans did not reflect people's histories, preferences and things that were important to them. It was not clear how people had been involved with the assessment and planning of their care. Prior to people entering the service a pre-admission assessment should have been completed to ensure the people's care and support needs would be understood. However, we saw that for two people this assessment had not been completed. This meant we could not be confident that people's needs would have been met or their preferences considered.

These issues meant there was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked to see if people knew how to raise any issues or concerns with the provider. The feedback we received was mixed. Some people knew how to make a complaint. One person said, "I would speak to the staff if I wasn't happy, and would then speak to the manager." One relative told us, "I have raised some issues with the owner; they did listen and were pleasant about things." However, other people who used the service were less clear how to do this. One person said, "I would speak to the boss if I had a complaint, but I don't know who that is." Another person commented, "I'm not sure what I'd do; I'd probably tell my relative." This meant the provider did not have an accessible, effective system in place to receive and act on complaints.

Inadequate

Is the service well-led?

Our findings

At our previous inspection, we found that improvements were required to ensure that the service was well led. At this inspection, we found that the required improvements had not been made.

The provider was not meeting their registration requirements, as they had not informed us about specific incidents that had occurred. For example, we saw that the local authority had authorised a deprivation of liberty safeguards application, and we had not received the notification about this. We were also made aware of other incidents that had occurred, and the provider had not informed us about these. For example, one person had been admitted into hospital after sustaining a head wound, and two others had fallen resulting in broken bones. We had not been notified of these injuries. We asked the provider to send us these notifications, which they did, however they had not initiated this themselves and the notifications were not sent in a timely manner.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009

The provider had some systems to monitor the quality of the service. However, we found these were not effective. For example, an audit had been completed regarding the management of medicines. However, this had not identified that some people who used the service took herbal remedies. The registered manager and provider were aware that these were being used, but had not re-instated the policy they had. Therefore, the provider had not followed appropriate guidance in relation to the safe storage and use of herbal remedies. The medicines audit had also not identified that there were gaps within the recording for the fridge temperatures where some medicines were stored. This meant the integrity of some medicines may have been compromised.

We found that when incidents had occurred, the provider did not have an effective system in place to analyse these events or to identify any possible trends. When people had fallen, their risk assessments were not reviewed to identify how any future risks could be managed. There had also been delays in contacting other professionals when needed. We could not be sure that the equipment used to support people following a fall had been checked. We received information from the local authority that there was not a system in place to monitor this equipment. This demonstrated the provider did not have processes in place to minimise the impact of risks for people who used the service..

Staff told us that they attended team meetings and that these were used for sharing information. We looked at the agenda from the most recent meeting and saw this focused on telling staff what they should be doing and what they had not done. We asked staff if there were opportunities for them to be involved in developing the service and if they were encouraged to do this. One staff member said, "No, not really." This demonstrated the provider did not actively encourage an open dialogue with staff to identify improvements within the home. Staff felt the registered manager and provider were approachable and they would be happy to speak with them if there were any issues. However, when asked if they received supervision to support them, one staff member told us, "Not for a long while now." This meant we could not be sure how the provider actively supported the staff and looked at their personal development.

There was a sign at the home stating that visiting times were restricted. One relative told us, "The restricted visiting hours can make it difficult for the family to come." We spoke with the provider about this. They told us this was in place to preserve people's privacy and dignity, particularly during meal times. We saw that the provider had made certain changes to the visiting times. However, this did not promote an open and welcoming culture for families and visiting professionals.

The provider had not consistently informed people when they had received feedback about the service. They had implemented a system to gain feedback from people who used the service and their relatives. We saw that a survey had been sent out 12 months previously. The provider told us that the next survey was due to be sent to people. When asked how the results and actions from this were shared, the provider informed us that they spoke with the individuals who had raised issues. This meant that other people would not have been informed and updated about the feedback received.

The above issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives felt the provider and registered manager were available to them. One relative commented, "The manager and owner are very pleasant; they ask me if things are okay." Another relative said, "They keep me informed of things they feel I need to know about." Staff spoke positively about working for the provider and felt they worked well as a team. The registered manager ensured that people's confidential records were kept securely.

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 18 Registration Regulations 2009 Notifications of other incidents The provider was not meeting their registration requirements, as they had not informed us about specific incidents that had occurred. Regulation 18

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not ensure that they carried out an assessment of the needs and preferences for care of all service users. The provider did not design care with a view to achieving service users preferences. Regulation 9(3)(a) and (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was not acting in accordance with the Mental Capacity Act 2005 and associated code of practice. Regulation 11(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not consistently managed. The provider had not assessed the risks to the health and safety of people when needed. The

provider had not done all that was reasonably practicable to mitigate any such risks.
Regulation 12(2)(a) and 12(2)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to assess, monitor and improve the quality and safety of the service. The provider did not have effective systems in place to assess, monitor and mitigate the risks relating to the safety and welfare of service users. The provider did not actively seek and act on feedback from relevant persons. Regulation 17(2)(a)(b)(e)