Adiemus Care Limited

# The Old Rectory

**Inspection report**

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Date of inspection visit: 6 Janaury 2015
Date of publication: 09/03/2015

## 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 6 January 2015 and was unannounced.

When we inspected this service in October 2014, we had major concerns regarding the lack of action taken by the provider when they had identified shortfalls in their audits monitoring the quality and safety of the service. We took action in response to our concerns and issued the provider with a warning notice. We carried out this inspection to check that the provider had taken action to improve the quality and safety of the service. We found that whilst some improvements had been made to the environment, we continued to be concerned about the leadership of the service, the high turnover of staff and the number of staff available to meet people's needs, at all times.

The Old Rectory is a residential care home which provides accommodation and personal care. support and It is registered for up to 60 people. On the day of our inspection there were 46 people living at the service.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

# Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

Although people told us that they felt safe this service was not providing consistently safe care. There was a high proportion of agency staff who did not have a knowledge of people's needs. Account had not been taken of people's needs when deciding on staffing levels which led to concerns about the ability of the service to ensure people's safety at all times.

We found staff to be kind and caring, however we remained concerned that staff did not always respond to people's needs in a timely way. We found that staff were focussed on the completion of tasks, such as the provision of meals and personal care with minimal engagement with the people they were supporting.

The provider was meeting the requirements of the Mental Capacity Act (2005).People's best interests had been assessed. Advice had been sought and best interests assessments requested from those qualified to do so where people's freedom of movement was being restricted in line with the Deprivation of Liberty Safeguards (DoLS). This helped to ensure people's rights were protected.

People's expressed preferences were not taken into account when preparing menus. Nutritional needs had been assessed and specialist advice sought when required. However, people had varied experiences at mealtimes as support from staff was not always provided in a caring, dignified manner and did not promote their health and wellbeing.

People had mixed experiences of staff. Whilst some told us staff were kind and caring others found staff focussed on tasks rather than them as a person.

Prior to our inspection we received information of concern that people's opportunities to enjoy social interaction with others whilst taking part in group activities had been reduced. They also told us that opportunities to pursue individualised leisure interests had been reduced as staff designated for this role had been assigned to work in the kitchen to cover for staff shortages.

# 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 safe.

People were concerned at the high turnover of staff and the numbers of agency staff being employed to cover staff shortages.

Although we were satisfied that the provider had taken action to recruit new staff we remained concerned at the provider's ability to maintain a stable workforce given the history of staff turnover.

The provider had a safe system in place for the recruitment of staff.

**Is the service effective?**

Requires Improvement

The service was not effective.

People had mixed views about the quality of staff and whether or not they had the skills to care for them effectively.

The manager had sought and acted on advice where they thought people's freedom was being restricted. This helped to ensure people's rights were protected.

Not all care plans contained up to date information to guide staff as to the current care needs of people.

**Is the service caring?**

Requires Improvement

The service was not caring.

Staffing shortages, the high use of agency and the lack of empathy displayed by some staff impacted on people's ability to experience care that promoted and enhanced their sense of wellbeing.

People and their relatives told us they had been provided with opportunities to express decisions about their care at their initial assessment prior to moving into the service.

**Is the service responsive?**

Requires Improvement

The service was not responsive.

Some aspects of the service were not responsive. Some people's needs had not been thoroughly and appropriately assessed and some people's support was not provided as agreed in their care plans. This meant people did not always receive support in the way they needed it.

People's opportunities to access social and leisure interests was limited and staff interactions and support was limited to task focussed activities.

There was a system in place to receive and handle complaints or concerns.

# Summary of findings

**Is the service well-led?**

Requires Improvement

The service was not well led.

Staff morale was low and staff turnover high. Staff did not find the manager approachable and responsive to their concerns.

Information requested from the manager conflicted with what staff, relatives and the operations manager told us and so was misleading.

During our visit we were made aware that staff on duty had been instructed by the manager to provide incorrect information to the inspectors. This impacted on our ability to have confidence in the manager to provide us with reliable information. We were therefore not assured that the service was well led with a culture of leadership that was reliable, open and transparent.

# 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 took place on 6 January 2015 and was unannounced.

The inspection team consisted of two inspectors and an expert by experience. An expert by experience has personal experience of using or caring for someone who uses this type of care service. Our expert had experience of caring for people living with dementia.

Prior to our inspection we asked the provider to complete a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We considered information which had been shared with us by the local authority. We also looked at safeguarding concerns reported to the Care Quality Commission (CQC). This is where one or more person's health, wellbeing or human rights may not have been properly protected and they may have suffered harm, abuse or neglect. This enabled us to ensure we were addressing potential areas of concern.

On the day we visited the service, we spoke with 10 People living at The Old Rectory, three relatives, four care staff, two senior staff, two domestic staff, the cook, the manager, the deputy manager and the operations manager.

Following our inspection we spoke with three relatives of people who used the service. We looked at four people's care records and carried out pathway tracking for three people. Pathway tracking is where we look at a person's care plan and check that this is being followed and their needs met. We did this by speaking with the staff that cared for them, observation of care provided and by looking at other records relating to how the provider monitored the quality and safety of the service.

We observed how care and support was provided to people throughout the day. Including the midday meal on two units. 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.

# Is the service safe?

## Our findings

At our inspection in October 2014, we were concerned that the provider had failed to ensure that sufficient numbers of staff were available to meet the needs of people who used the service at all times. We issued the provider with a warning notice. The purpose of this inspection was to check that improvements had been made to ensure the safety and welfare of people.

We found continued concerns in relation to the numbers of staff available to meet people's needs. People told us that they felt safe in the service. However, they and their relatives also told us that there were not enough staff to meet people's needs. People expressed their concern at the high turnover of staff and the numbers of agency staff being employed to cover staff shortages. One person told us, "You just don't know who is going to help you with a wash. The faces keep changing." Another said, "There are never enough, and they don't stay here long."

One relative told us that their relative had on the morning of our visit been waiting 25 minutes for a member of staff to support them with their personal care needs. They said, "We have been ringing the bell and I have been down and found a carer about ten minutes ago who said they would come straight away, but still nobody has come yet." We were not assured that people received personalised care that was responsive to their needs.

One person said, "You hardly see anyone. There are not enough staff and they are not very quick at responding to call bells. I am at risk of falling and they know that." We observed that few people had access to a call bell if they required support from staff whilst sat in the lounge areas. All the people we spoke with did not know the location of call bells within communal areas and the majority of people could not access these if they were unable to mobilise independently.

We observed one person during the mid-morning request a cup of tea. Care staff responded by saying, "We have run out of milk, but it will be lunch soon." This person was observed to not receive a response to their request for a cup of tea until mid-afternoon. This demonstrated a lack of responsive care towards this person.

We noted that some agency staff appeared directionless and stood waiting for further instructions before being able to respond to people's needs. Care staff told us of their frustration at the high numbers of agency staff being used by the provider. They told us this was as a result of a high turnover of staff and absenteeism. Staff said the prolonged use of agency staff meant that it was necessary for them to supervise the agency staff as they did not know the needs of people who used the service which impacted on the time they had to provide care. We observed one person calling out from their room who sounded distressed. Our expert by experience asked an agency worker if they knew anything about this person and what their needs were. The agency worker told us they knew very little about this person and was not sure what to do. One relative told us, "I am concerned at the turnover of staff. Most of the staff who have been working at the home for ages have left. This concerns me as it is my belief that people with dementia need familiar faces and this is not happening. There can't be enough staff when you think how long [my relative] has to wait when they ring the bell. They are all run off their feet. They do their best."

Rotas viewed demonstrated that there had been variations in the numbers of staff available. With occasions within the last four weeks when there were insufficient numbers of staff available. This impacted on the provider's ability to provide consistent, safe care for people. We requested, from the operations manager a list of the staff that had left since our last inspection in October 2014. We noted that 12 staff had left with another member of staff leaving the day after our visit. A relative told us, "We have serious concerns about the level of staffing and general running of this home. We visit regularly and have noticed that the staffing situation has become extremely worrying. There is no consistency of care. There is a constant change in the staff you rarely find anyone who knows [my relative] well enough. How would you feel if you had a constant stream of strangers helping you with your personal care? "Concerns in relation to the high turnover of staff were identified at our last inspection. The provider had recruited staff to fill vacant posts with newly appointed staff due to start working at the service the following week. Although we were satisfied that the provider had taken action to recruit new staff we remained concerned at the provider's inability to maintain a stable workforce given the continued high turnover of staff. We were therefore not assured that the safety and welfare needs of people would be consistently met by sufficient numbers of staff.

# Is the service safe?

This demonstrated a continual breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

There was a system in place to record accidents and incidents. People's care records contained risk assessments. These were regularly reviewed and covered a wide range of areas. For example, where people had been identified as at risk of falling. The action plan identified actions to take to guide staff in reducing the risk Records documented where alternative options had been considered which enabled people to take informed risks.

The provider's safeguarding adults and whistle blowing policies and procedures informed staff of their responsibilities to ensure that people were protected from harm. Staff confirmed they had received training in safeguarding people from the risk of abuse. They described their understanding regarding the different types of abuse and what they would do if they suspected abuse had taken place in the service. The manager had reported safeguarding incidents to the relevant authorities including the Care Quality Commission as is required. This demonstrated that the manager and staff had the required knowledge to safeguard people from abuse.

The provider had a safe system in place for the recruitment of staff. Recruitment records and discussions with staff showed us that checks had been carried out by the provider to make sure that the staff they employed were of good character and were safe to work with vulnerable adults.

The manager and senior staff completed regular medication audits to check that medicines were being obtained, stored, administered and disposed of appropriately. Staff had received up to date medication training and had been competency assessed to confirm they had the skills needed to

administer medicines safely. These measures ensured that staff consistently managed medicines in a safe way. We reviewed the provider's recent monthly compliance audit and found that where medication errors had been identified, action plans had been put in place which included timescales for the manger to ensure compliance.

# Is the service effective?

## Our findings

People and their relatives gave mixed views on whether they felt staff had the skills and knowledge to care for them. One person told us, "There are some who know just what to do, the regular staff who have been here a while but others could do with more training. The agency staff don't always know what they are doing." Another told us, "There are far too many agency staff, they do not know you and don't know what you need. I have to tell them what I need and how to do it but how do people get on who can't talk and tell them they need?"

The providers information return (PIR) stated that all staff received regular supervision with a senior member of staff where opportunities had been provided for staff to discuss their training needs and performance. Senior staff delegated to provide supervision support to staff told us that given the staffing shortages they had not had time to meet with staff in accordance with the provider's policy for staff to receive supervision support bi-monthly. One member of staff told us, "I don't remember the last time I had supervision or was able to provide supervision to the staff I have. There just isn't time." Staff told us this impacted on their being provided with opportunities to discuss their personal development and any concerns they might have.

All the staff we spoke with confirmed they had received training in understanding their roles and responsibilities with regards to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Best interest assessments had been carried out to determine if care provided restricted people's freedom of movement. The manager had sought and acted on advice where they thought people's freedom was being restricted. This helped to ensure people's rights were protected.

We received mixed views from people regarding the quality and variety of food provided such as, "The food is not very good but what do you expect in a place cooking for so many?", "It is all very samey, a lot of casseroles, which have never been my kind of food", "The menus sound great but the eating of it is a disappointment, unappetising and uninteresting. No one ever asks you if you have enjoyed your meal" and "I can't complain, it's nice having your food cooked for you." People's food preferences had been recorded on admission and the support required identified. However it was not evident that food provided was consistent with people's expressed preferences. Considered in light of people's preferences and their choices assessed.

Agency staff told us they did not have access to care plans and risk assessments apart from observational notes located within people's rooms which contained only a summary of their care plan and no guidance for staff in the management of risks. One person we observed with complex health care needs was being cared for in bed. We noted that food and fluid charts only recorded mouth care provided by staff for the last two days. There was no record of any food and fluid having been provided. Staff gave differing accounts as to how they had been instructed to support this person in relation to their pressure area care and their food and fluid intake. The care plan had not been updated to reflect their current care needs. There was a potential risk of the person not receiving personalised care, responsive to their current health, welfare and safety needs. The manager responded immediately to our concerns and instructed staff on duty in accordance with recent advice received from the person's general practitioner on how best to support this person. Handover records were also amended to provide staff with this up to date guidance to enable effective communication.

People had access to a range of health care professionals which included general practitioners, dieticians and community nurses in response to health concerns that had been identified. A record of people's weight had been monitored regularly and people assessed for risk of malnutrition using nutritional risk assessment tools. Where people had been highlighted as at risk of malnutrition, they had been referred to the dietician or speech and language therapist. Food and fluid charts had been updated with amounts of food and fluid consumed.

# Is the service caring?

## Our findings

People gave us mixed views when asked about the manner in which they were supported by staff, “Some staff are very nice and kind to you”, The carers are lovely people, and obliging, but they don’t have much time for you, they are too busy”, “Most staff will chat to me, but I can see their minds are elsewhere, thinking about what they have to do next, so they are always in a rush” and “Some staff treat you more like a patient rather than a person.”

The interactions we observed between staff and people in the main were polite but staff had little time to chat or engaging generally with people other than to attend to their personal care needs or when supporting with their meals. We found that staff were focussed on the completion of tasks, such as the provision of meals and personal care with minimal engagement with people. One person told us, “They don’t have time to get to know me as a person or find out what is important to me, they promise to do something then don’t get round to it. To me that is not caring.” Another told us, “Sometimes I think of what I used to be. They just see an old person and forget I used to be young like them once.”

We observed staff supporting people with eating their meals during the lunch time period. One member of staff supported a person in their room in a manner that was caring, considerate as they chatted positively with the person throughout. However, this was not consistent across the service. Two staff were observed to sit on the arm of people’s chairs when supporting them to eat their meal. They did not talk to the person throughout the activity other than to say “here you are” whilst spooning food into their mouth. They also watched television throughout the activity. Another member of staff was observed trying to support one person with eating their meal whilst getting up frequently to serve food and support other people. Staff providing care and support whilst distracted by other tasks and with a lack of empathy meant people did not experience care that promoted their sense of wellbeing.

A recent survey highlighted concerns people had expressed regarding the lack of privacy they experienced as some staff did not routinely knock on bedroom doors before entering. The manager had recorded in their action plan that this would be discussed and addressed with staff at the next staff meeting. We observed staff to knock on people’s door and wait before entering. People told us that their privacy and dignity was protected when staff supported them with their personal care.

People and their relatives told us they had been provided with opportunities to express decisions about their care at their initial assessment prior to moving into the service. Residents meetings had taken place on two occasions within the 12 months where people had been asked their views about the quality of the food and their opinions sought in planning social and leisure opportunities. However, people told us they limited opportunities to review their care and express their choices and preferences in how they lived their daily lives

# Is the service responsive?

## Our findings

People did not always receive personalised care that was responsive to their needs. Care records reviewed showed us that people's needs had been assessed before they were offered accommodation at the service. The information obtained had been used to develop detailed care plans which had information regarding people's preferences when supported with personal care as well as their health care needs. However, people told us they did not have regular access to baths and showers in accordance with their assessed need, choices and preferences. One person told us, "I have not had a bath for three weeks. Staff tell me they are too busy." A relative told us, "My [relative] tells me they do not always get the baths they need; [relative] tells me they have to wait and remind the staff that they need a bath."

People's care plans had space to include personal life histories, these were not always completed or the information contained was limited. We discussed this with staff who told us that it was difficult to gather this information if the person lacked the capacity to communicate their life history and when there was limited family involvement.

Care plans described people's hobbies, interest's and social preferences. For example one person's care plan described their hobbies as gardening and described how they enjoyed the outdoors. Discussions with staff and a review of their daily notes showed us that this person had not been provided with opportunities to access the local community or communal gardens.

People's opportunities to access social and leisure interests was limited and staff interactions and support was limited to task focussed activities. People and their relatives told us that planned groups activities had been cancelled on several occasions within the last month. They described how this impacted on their ability to enjoy social interaction and opportunities for stimulation and leisure opportunities on a consistent basis. One person told us, "Sometimes there is some outside entertainment but often I sit for hours just looking at four walls. It can get very monotonous." We observed throughout our visit people were left for significant periods of time with little interaction from staff.

We asked the manager how they routinely listened and learnt from people's experiences, concerns and complaints. They told us they carried out regular residents and relatives meetings. A review of meeting minutes showed us that only two residents meetings had been held within the last 12 months. People had been asked their views about the quality of food. All comments recorded within the meeting minutes were positive. This contradicted the views of the majority of people we had spoken with. The manager told us they conducted regular satisfaction surveys. Action plans had been produced which described how the manager would respond to the concerns identified. For example, one person had stated that not all staff knocked when they entered their room. The manager had recorded within their action plan that this would be discussed with staff at the next staff meeting.

The complaint's policy and procedure was displayed within the service. This contained contact information and timescales for responding to complaints. One relative told us, "I feel that I personally could say what I wanted to and complain to the manager if I was unhappy about anything but I Know [my relative] would not speak up as they would be afraid they would be treated differently by staff."

# Is the service well-led?

## Our findings

When we inspected this service in October 2014, we had major concerns regarding the lack of action taken by the provider when they had identified shortfalls in their audits monitoring the quality and safety of the service. We took action in response to our concerns and issued the provider with a warning notice. We carried out this inspection to check that the provider had taken action to improve the quality and safety of the service. We found that whilst some improvements had been made to the environment, additional staff employed, we continued to be concerned about the leadership of the service, the high turnover of staff and the number of staff available to meet people's needs, at all times.

We found that the service was not well led. People told us, "There has been a lot of discontent here. A lot of good staff have left, I don't know why but some have said they couldn't put up with things the way they are being run at the moment" and "The place is going to pot. Staff are leaving. It is not the place it was when I moved in a couple of years ago."

Relatives told us when asked for their views about the leadership of this service, "They could do a lot better. Things have gone downhill. Staff who have been here a long time have now gone" and "There has been a huge turnover of staff with long serving employees leaving. We feel this is due in part to poor management of the service."

All of the staff we spoke with told us that the morale of the staff team was low. One staff member told us, "I have never known the morale to be so low, it is at rock bottom." Another told us, "This is not a happy place to work." We asked staff what they believed had contributed to the low morale of staff. One told us, "There is never any praise for the good work you do. Staff meetings are used to give you a good telling off. Pointing out all the things we don't do but never the recognising the good we do." Another told us, "If the manager takes a dislike to you then you are in for a hard time. Staff don't stay here long." All of the staff we spoke with told us that the constant turnover of staff and the high use of agency staff impacted on their ability to meet people's needs well and ensure consistency of care for people.

We requested information from the manager with regards to the number of vacant staffing hours as well as details of the number of staff who had left their employment since our last inspection in October 2014. Information provided was inconsistent and did not relate to what we found. The information we were provided with conflicted with what staff, relatives and the operations manager told us and so was misleading.

During our visit we were made aware that staff on duty had been instructed by the manager to provide incorrect information to inspectors. This impacted on our ability to have confidence in the manager to provide us with reliable information. We were therefore not assured that the service was well led with a culture of leadership that was reliable, open and transparent. We discussed our findings with the provider who took immediate and appropriate action in response to our concerns.

The provider had a system in place to respond to concerns and complaints which detailed timescales for responding to concerns and guidance for managers to record the action they had taken in response and the outcomes. Records we reviewed demonstrated that complaints had not been responded to according to the provider's policy. Not all complaints received within the last 12 months evidenced the timescales taken to respond and the outcome of complaints with a record of the action taken by the provider. We were therefore not assured that the provider routinely listened to the views of people, considered the impact of how care was provided and used their findings to plan for improvement of the service.

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 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 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing<br><br>**Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010**<br><br>Staffing<br><br>**The registered person did not safeguard the health, welfare and safety of people by ensuring that sufficient numbers of suitably qualified, skilled and experienced staff were provided at all times.**<br><br>Regulation 22 |