Tudor Care plc

Old Rectory (Bramshall) Limited

Inspection report

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Ratings

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

Overall summary

We inspected this service on 8 May 2015. This was an unannounced inspection.

The service was registered to provide accommodation and nursing care for up to 30 people. At the time of our inspection 28 people were using the service. People who used the service had physical health needs and/or were living with dementia.

Our last inspection took place on 17 September 2014. During that inspection two Regulatory breaches were identified. We told the provider that improvements were required to ensure people received care that was safe and effective. At this inspection we found that the required improvements had not been made.

Summary of findings

The service did not have a registered manager. 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 and associated Regulations about how the service is run. The provider told us that a new manager had been recruited and they would be registering with us after their induction.

At this inspection we identified areas of unsafe, ineffective and unresponsive care. This was because the service was not well led. We found a number of 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.

There were insufficient numbers of staff to keep people safe and provide the right care at the right time. This also meant that people's individual care needs and preferences were not always met.

Some people who used the service were unable to make certain decisions about their care. In these circumstances the legal requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) were not being followed. The Mental Capacity Act 2005 and the DoLS set out the requirements that ensure where appropriate, decisions are made in people's best interests when they are unable to do this for themselves. This meant people could not be assured that decisions were being made in their best interests when they were unable to make decisions for themselves.

The provider did not have effective systems in place to assess, monitor and improve the quality of care. This meant that poor care was not being identified and rectified by the provider.

Risks to people's health and wellbeing were not consistently managed and reviewed which meant people did not always receive safe care.

Staff did not know how to report alleged abuse to the local authority and records relating to people's medicines needs were not always accurate. This meant that effective systems were not in place to ensure people's safety and wellbeing needs were met.

There were gaps in the staffs' knowledge and skills that meant some people's specialist needs were not met effectively.

People were not always supported to eat at the right time and the staff could not always show that people's risk of malnutrition were being managed safely.

People's feedback about care was not sought which meant the registered manager and provider could not use people's feedback to make improvements to the quality of care.

When staff had the time they supported people with care, compassion and respect. However, we saw that the staff did not always have the time to consistently support people in this manner.

Systems were in place that enabled people to receive end of life care that met their preferences and people were protected from the risk of infection.

People were involved in the planning of their care and they were able to participate in social and leisure based activities of their choice.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection

Summary of findings

will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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?

The service was not consistently safe. Risks to people's health and wellbeing were not consistently managed and reviewed, and staff did not know the correct reporting procedures to protect people from abuse.

There were insufficient numbers of staff to meet people's individual needs and keep people safe. People could not be assured that their medicines were managed safely.

Requires Improvement

Is the service effective?

The service was not consistently effective. The staff did not always follow the legal requirements to ensure the rights of people who were unable to make decisions about their care were protected.

There were gaps in the staffs' knowledge and skills which meant some people's specialist needs were not met effectively.

People's individual nutritional needs were not always met and people did not always receive the support they needed to manage their risk of malnutrition.

Inadequate

Is the service caring?

The service was not consistently caring. People did not always receive care and support with compassion and in a manner that promoted their dignity.

Systems were in place to enable people to receive end of life care that met their preferences and needs.

Requires Improvement

Is the service responsive?

The service was not consistently responsive. People did not always receive care that met their individual needs.

People told us they were involved in the planning of their care and people felt happy sharing concerns about their care to the staff.

Requires Improvement

Is the service well-led?

The service was not well-led. Effective systems were not in place to assess, monitor and improve the quality of care. This meant that poor care was not being identified and rectified by the provider.

The provider had not taken action to make the required improvements after our last inspection.

Inadequate

Old Rectory (Bramshall) Limited

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 was 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 8 May 2015 and was unannounced. Our inspection team consisted of two inspectors.

We checked the information we held about the service and provider. This included the notifications that the provider had sent to us about incidents at the service and information we had received from the public. We used this information to formulate our inspection plan. We had received information of concern about how the risks of infection were being managed and we saw that the majority of the deaths that occurred at the service were expected due to illness or disease. As a result of this information we chose to cover additional key lines of enquiry. These included how the staff managed the risk of infection and how end of life care was delivered.

The provider was sent 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. The provider told us they had not received or completed their PIR.

We spoke with 10 people who used the service and two relatives. We also spoke with three members of care staff and the provider's nominated individual. We did this to gain people's views about the care and to check that standards of care were being met.

We spent time observing how people received care and support in communal areas and we looked at five people's care records to see if their records were accurate and up to date. We also looked at records relating to the management of the service. These included safety checks, staff records and training records.

Requires Improvement

Is the service safe?

Our findings

People told us they had noticed the staff had recently become increasingly busy which impacted on their care. One person said, "There seems to have been a reduction in the numbers of staff as they don't seem to be around as much". Another person said, "The staff don't really have time to talk to me anymore". Staff confirmed that people's needs had increased and there was not always enough staff available to keep people safe. One staff member said, "Three care staff used to be enough in an afternoon, but now we could do with more because we have more doubles [people who require assistance of two] so another pair of hands would really help". Another staff member told us that they assisted one person to move without the required assistance of a second staff member because staff were not available to support them. They said, "Ideally they need two staff, but the others were busy".

We saw that there were not enough staff to keep people safe. We observed one person who used the service support another person who used the service to drink a cup of tea on two occasions when staff were not present in the lounge. Supporting someone to drink without the understanding or skills to do so could result in harm, such as choking. This person was at risk of choking because of their poor seating position. This meant that this person's safety and wellbeing needs were not met by the staff.

The provider told us that staffing levels needed to be reviewed as the needs of people had recently changed. They said, "We have taken on more residents quickly this last month and lost staff which has left us short on a couple of shifts".

The above evidence shows that the lack of sufficient numbers of staff meant that people's individual needs were not met and people's safety and welfare were compromised. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they received their medicines when they needed them and we saw that medicines were stored safely. However, effective recording systems were not in place to ensure an accurate account of the medicines people received were maintained. We found that the quantities of medicines listed on people's Medication Administration Records (MAR) did not match the numbers of medicines stored at the home. Four of the five medicines we counted did not match the numbers recorded on the MAR. These discrepancies showed that people's MAR were not accurately maintained.

We saw that risks to people's safety were not always effectively assessed and managed. One person's care plan stated they needed assistance to move using a standing hoist, but the care plan didn't specify how many care staff should provide the assistance required to promote their safety. Best practice guidance from the Health and Safety Executive recommends that two staff should operate a standing hoist to ensure people's safety and wellbeing. However, we observed one staff member support this person to move using the standing hoist. Staff confirmed this person's behaviour was unpredictable which increased their risk of becoming agitated and uncooperative when staff assisted them to move. This meant the person's risk of harm or injury whilst being assisted to move had not been effectively assessed or managed.

Another person told us and their care records showed that they frequently fell. Their care records showed they had been assessed as being at high risk of falling, but an effective management plan was not in place to manage or reduce their risk of falling. The provider confirmed that in the absence of a manager incidents at the service were not being effectively analysed to ensure action was taken to reduce the risk of further incidents occurring.

Staff did not know how to protect people from abuse. We found that effective systems were not in place to ensure suspected abuse would be reported in accordance with the local authorities safeguarding procedures. The agreed local safeguarding procedure is that staff should immediately report safeguarding concerns and incidents to them so they can consider if any action is required to manage or minimise further incidents from occurring. None of the staff we spoke with knew the contact details for the local safeguarding team.

People told us the home was always clean and tidy. One person said, "My room is always spotless". We found that effective systems were in place to protect people from the risk of infection. Staff understood and followed the service's infection control policy and procedures. For example, domestic staff told us and we saw that they reduced the

Requires Improvement

Is the service safe?

risk of infection by using colour coded cleaning equipment for different areas of the home. We also observed care staff using protective equipment such as, gloves and aprons when they delivered care and support.

Inadequate

Is the service effective?

Our findings

Some people who used the service were unable to make certain decisions about their care. The Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) set out requirements to ensure that decisions are made in people's best interests when they lack sufficient capacity to be able to do this for themselves. Although the staff told us about the basic principles of the Act, we saw that the assessments they completed to assess people's capacity did not always follow the legal guidance. For example, we saw that mental capacity assessments were not always decision specific. One person had been unable to answer a question about where their bedroom was located. As they were unable to answer this question, they had been judged as not having the capacity to make decisions about their personal care, healthcare, treatments and finances. Not consistently following the legal guidance meant that people could not always be assured that their rights to make decisions about their care were being consistently protected.

We asked the staff if any people who used the service were being restricted within the home's environment in their best interests under the DoLS. We were informed that no one had or required a DoLS authorisation because no restrictions were in place. We identified one person who was at times being deprived of their liberty because they were sometimes moved to their bedroom when they displayed behaviours that impacted upon other people. Staff told us the person did not have the capacity to make the decision to move to their bedroom under these circumstances and they did this because they were acting in the person's best interests. The staff agreed that a DoLS referral was required and confirmed they would complete this. This meant that the staff had failed to independently recognise that this person was potentially being restricted and required a DoLS assessment.

None of the staff we spoke with were able to tell us about the current requirements of the DoLS and how to identify when people were restrained or subject to any restriction. This meant that staff could not act in accordance with legislation when people were unable to make certain decisions about their care.

The above evidence shows that effective systems were not in place to ensure people were lawfully restricted when this was required. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that people did not always get the support they needed to enable them to eat and drink. For example, we saw that one person whose care records stated they required, 'plenty of encouragement with their diet' did not get the encouragement they needed to eat their breakfast. The person had to wait a significant time before a staff member actively supported them to eat their breakfast. However, by this time the person had become drowsy and was unable to eat. This person remained asleep during lunch so they also did not receive their lunch time meal. Staff told us this person's appetite and ability to eat regularly fluctuated and they needed supervision with eating to ensure they ate well. However, no explanation was given as to why the person had not received the supervision and support they required during our inspection.

The person's care records showed they had lost weight over a short period of time and were at risk of malnutrition. Despite this weight loss, the person had not been recently weighed to identify if further weight loss had occurred and no advice had been sought from health professionals regarding their identified weight loss. The nurse we spoke with about this agreed that the person's weight loss needed to be communicated to their doctor as they were at risk of malnutrition.

The above evidence shows that this person's risk of malnutrition was not being effectively managed or monitored. This was breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they enjoyed the food. One person said, "The food is wonderful, yesterday's beef stroganoff was gorgeous". Another person said, "The food is very nice. However, people confirmed that they were not given varied meal choices. One person told us, "I've never been given a meal I don't like, but it would be nice to get a choice". Another person said, "There are no meal choices, I assume it's got something to do with costs". We saw that people

were offered limited food choices. For example, people could choose from fish, chips and peas or fish, mash and peas. This showed that there was little difference in the two choices presented to people.

We saw that alternative food choices were not always given to people who had specialist nutritional needs. For example, we saw that when tea and biscuits were served to people, one person was told by a staff member, "You know you can't have one [a biscuit]". Staff told us this person was unable to eat biscuits as they required foods that were easy to swallow. This person was not offered an alternative by the staff and staff gave no reason for this. We asked the person if they would have liked to have had a snack with their tea. They told us they would have liked one.

Staff told us and records showed that regular training was provided. Staff also told us that they had been receiving regular support in the form of supervision until the previous manager left their role. The provider told us that a new manager had been recruited and staff supervision would now resume. Our observations showed that people's specialist needs were not always met because there were some gaps in the staff's knowledge and skills. For example, we saw that staff managed one person's behaviours that challenged inconsistently. This person frequently shouted out and at times was verbally aggressive. We saw four different staff member's manage this person's behaviours differently, which resulted in different outcomes for the person. All the staff we spoke with confirmed they had not received training to enable them to manage people's behaviours that challenged. The provider told us they were aware of the training gaps and were in the process of sourcing training to address these gaps.

Requires Improvement

Is the service caring?

Our findings

People told us that the staff were kind and caring. One person said, "They are very caring". Another person said, "The nurse told me I have beautiful twinkling eyes this morning". However, some people told us that staff were often too busy to provide them with reassurance and comfort. One person said, "I would like someone to knock on my door occasionally and ask if I'm alright, because very often I'm not alright".

We saw that staff did not always have time to treat people with compassion. We observed that three people were ignored by staff at times. One person shouted "Please help me" when they were waiting to be supported to eat. This person's shouts were ignored. Another person shouted "Please don't shut the door" as the staff member closed their bedroom door. The staff member heard the person shout this, and they told us that the door needed to remain closed as it was a fire door. We went into the person's room to offer reassurance as they continued to shout and we requested support from another staff member. A third person's agitation and distress was dismissed by a staff member at lunch time. This person had become agitated during the morning and was expressing this at lunch time. A staff member responded to the person's distress by saying, "They are just moaning about [a member of staff]" to another member of staff who was present in the room. No reassurance was given to the person.

We saw that when staff directly supported people they promoted their dignity. For example, one person was discreetly given the resources they required to enable them to manage their swallowing difficulties. People were offered aprons at lunchtime to help keep their clothes clean and the staff respected people's choices to wear or not wear aprons. However, we saw that the staff did not always have the time to ensure that people's dignity was consistently maintained. For example, when one person started to shout when they became distressed and agitated, we heard other people who used the service shouting back at the person. No staff were not present to intervene to prevent the person from being shouted at by other people who used the service.

People told us they were offered some choices about their care. For example, one person told us staff gave them choices about how their personal care needs were met. They said staff gave them choices about when to get up in a morning and offered them choices of clothing to wear, and they told us the choices they made were respected by the staff. We found that more choices could be offered to people to ensure they were also involved in making choices about other areas of their care. For example, more meal choices could be offered.

There were systems in place that enabled people to receive dignified and pain free end of life care. For example, one person who had been identified as requiring end of life care had an advanced care plan in place that outlined their preferred place of death. We saw that when their health had deteriorated the staff had respected their wishes not to be admitted to hospital. Anticipatory medicines had been requested and were in place. These medicines are used to manage people's symptoms during their end of life care and they help people to experience a pain free and dignified death. The provision of anticipatory medicines ensured that medicines were available to people at the right time to enable them to receive their end of life care in their preferred place. Improvements were required to ensure people's end of life care needs were recorded so that people could be assured their end of life needs would be met consistently.

The relative of a person who was receiving end of life care told us that the staff extended their care and support to the relatives of people who used the service. They said, "The staff have given me hugs when needed" and, "The staff have been compassionate and strong which is what my family has needed". This showed that the staff also supported the families of people who were receiving end of life care.

Requires Improvement

Is the service responsive?

Our findings

We found that the specialist needs of some people were not being met. For example, one person was unable to sit upright in their chair. Staff confirmed that the person regularly struggled to maintain a comfortable and safe sitting position. Staff also confirmed and the person's care records showed that no consideration had been given to assess the person's seating needs.

We saw that the needs of people with behaviours that challenged were not being managed effectively. Staff told us that one person's trigger for their behaviour that challenged was their relatives leaving after they had visited. After the person's relative left, we observed them displaying signs of distress and agitation in the form of shouting out. The person was observed to be shouting out for a significant period of time before another person who used the service called for the staff to assist and reassure the person. Staff were aware that the person's relative had left as we saw them say goodbye as they left, but no attempt was made to prevent this agitation from occurring. For example, no staff member went to sit with the person to reassure them when their relative left. This showed that despite knowing that the person was likely to become distressed and agitated, no attempt was made to prevent this agitation from occurring.

People told us they were involved in the planning of their care. A relative told us, "They came and did an assessment before [person who used the service] moved here. They asked them what they liked to do, and the staff seem to know what [person who used the service] likes. They know what their favourite biscuits are and that they like knitting". A person who used the service told us that they had recorded how they wanted their care to be delivered on the morning of our inspection as they had an early appointment to attend. They confirmed that the staff had read their instructions and they had supported them to receive their care in accordance with their preferences. This showed that people were encouraged to be involved in planning their care.

People told us they could participate in social, leisure and spiritual based activities that met their individual preferences. One person said, "There's always something going on, it's bingo today and I like bingo". Another person said, "Yesterday we had communion, it was fantastic. A lady comes in once a month to do exercises with us and a hairdresser comes once a week". People told us their decisions not to join in activities were also respected. One person said, "I stay in my room because I have everything I need in here. I can watch TV or read, I don't need to go to the lounge". Another person said, "They tell me about the activities, but I choose not to join in".

People told us they were not aware of a formal complaints procedure. However, they would be happy to share their concerns with the staff and provider. One person said, "I would tell the staff if I needed to complain. I know they would listen to me". Another person confirmed that a concern they had raised to the provider was listened to and managed to their satisfaction. They said, "I told the owner I wasn't happy with something and it got changed". This showed that people's concerns and complaints were being managed effectively.

Inadequate

Is the service well-led?

Our findings

At our last inspection we found that people were not protected from the risk of receiving unsafe or inappropriate care because accurate and up to date care records were not maintained or stored securely. This meant the provider was in breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to send us a plan outlining how they were going to make improvements to the care. We did not receive this plan and the provider could not share an improvement plan when we asked for this during this inspection

At this inspection, we found that further improvements were required. Care records were still not stored securely and checks of care records and medicines were not being completed. This meant that the concerns we identified with medicines recording and the lack of care plans for specialist needs such as, seating and behaviours that challenged had not been identified by the provider.

At our last inspection we also found that people were not consistently protected from the risk of unsafe or inappropriate care because equipment was not always used correctly. This meant the provider was in breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we saw that the required improvements had not been made. Staff competency checks were not being completed. For example, no checks were in place to ensure staff had understood their moving and handling training. The provider had not identified that staff were not consistently using moving and handling equipment safely which meant people were at risk of harm.

None of the staff we spoke with could tell us about any changes or improvements in care and staff confirmed that their opinions about the quality of care were not sought. This showed that staff were not involved or empowered to make improvements to the quality of care.

People's views about the quality of care were not listened to or acted upon. The provider told us that people's feedback about the quality of care had been sought in the form of a satisfaction questionnaire. However, the provider confirmed that the content of the returned questionnaires had not yet been analysed. We saw that suggestions for improvements to the environment and activity provision had been made by people who used the service. For example, people had asked for outside seating areas, but the provider confirmed that no action had been taken to address this need.

The provider had failed to recognise that there were insufficient numbers of staff to meet people's individual needs and promote a positive and caring atmosphere. One person said, "The staff are lovely and friendly and they try their best, but they are so busy and are not always around". We saw that when the staff were present in communal areas, people were happy and settled. However, when staff were busy and not present in communal areas, some people began to display behaviours that challenged others, such as; shouting at each other. People told us and we saw that this had a negative impact on people. For example, two people told us they moved away from communal areas during these times as it upset them.

The above evidence shows that effective systems were not in place to ensure the quality of care was regularly assessed, monitored and improved. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was not open and honest about the quality of care at the service. An old inspection report where no concerns had been identified was on display in the reception area of the home, rather than the last inspection report where concerns about care had been identified. People we spoke with confirmed they had not been made aware of the outcome of the last inspection.

People told us they had noticed a change in how care was delivered in the absence of a registered manager. One person said, "Recently, there has been a deterioration in the care. I pay a lot of money and expect a better service". Another person said, "There's no manager here, that's the problem". The provider told us they had recruited a new manager and they were due to start the following week.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Risks to people's safety were not effectively managed. Regulation 12 (1), (2), (a) and (b).

The enforcement action we took:
We served a warning notice to the provider telling them to make immediate improvements to the quality of care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Systems were not in place to prevent people from being unlawfully restricted. Regulation 13 (5).

The enforcement action we took:
We served a warning notice to the provider telling them to make immediate improvements to the quality of care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Effective systems were not in place to ensure risks to people's safety and welfare were consistently assessed, monitored and managed. Regulation 17 (1), (2) (a), (b), (c), (d), (d) (ii), (e), (f) and (3) (b).

The enforcement action we took:
We served a warning notice to the provider telling them to make immediate improvements to the quality of care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were insufficient numbers of staff to meet people's individual needs and keep people safe. Regulation 18 (1).

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
We served a warning notice to the provider telling them to make immediate improvements to the quality of care.