Oakprice Limited

The Old Rectory

Inspection report

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Ratings

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

Overall summary

This unannounced inspection took place on 8 December 2015. We returned on 11 and 15 December 2015 as arranged with the management team. This inspection was brought forward in response to receiving information of concern about how people were spoken to by staff, a lack of incident reporting to the local authority safeguarding team, staff having limited access to care files and new staff receiving a poor induction when starting work at The Old Rectory. We were unable to substantiate these concerns during our inspection, apart from staff receiving a limited induction when starting work at the home and a lack of incident reporting. Our last inspection in December 2013 found the service to be meeting all of the Health and Social Care Act 2008 regulations inspected.

The Old Rectory is a 15 bedded care home for people with learning disabilities which is spread over four units. It specialises in caring for people with autism spectrum disorder and health, emotional and behavioural needs. At the time of our inspection there were 13 people living at The Old Rectory.

Summary of findings

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.

On one occasion consent for care and treatment was not given in accordance with the Mental Capacity Act 2005.

Staff did not receive a comprehensive induction when they started working for the service to enable them to carry out their duties they were employed to perform.

There were effective staff recruitment and selection processes in place. Staffing arrangements were flexible in order to meet people's individual needs. Existing staff received a range of training and regular support to keep their skills up to date in order to support people appropriately. Staff spoke positively about communication and how the registered manager worked well with them, encouraged team working and an open culture.

People felt safe and staff demonstrated a good understanding of what constituted abuse and how to report if concerns were raised. Measures to manage risk were as least restrictive as possible to protect people's freedom. Medicines were safely managed on people's behalf.

Care files were personalised to reflect people's personal preferences. Their views and suggestions were taken into account to improve the service. They were supported to maintain a balanced diet, which they enjoyed. Health and social care professionals were regularly involved in people's care to ensure they received the care and treatment which was right for them.

Staff relationships with people were strong, caring and supportive. Staff were motivated and inspired to offer care that was kind and compassionate.

A number of effective methods were used to assess the quality and safety of the service people received.

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 safe.

People said they felt safe and staff were able to demonstrate a good understanding of what constituted abuse and how to report if concerns were raised. People's risks were managed well to ensure their safety.

Staffing arrangements were flexible in order to meet people's individual needs.

There were effective recruitment and selection processes in place.

Medicines were safely managed.

Good

Is the service effective?
The service was not effective.

On one occasion consent for care and treatment was not given in accordance with the Mental Capacity Act 2005.

Staff did not receive a comprehensive induction when they started working for the service to enable them to carry out their duties they were employed to perform.

People's health needs were managed well through contact with community health professionals.

People were supported to maintain a balanced diet, which they enjoyed.

Requires improvement

Is the service caring?
The service was caring.

People said staff were caring and kind.

Staff relationships with people were strong, caring and supportive. Staff spoke confidently about people's specific needs and how they liked to be supported.

People were able to express their views and be actively involved in making decisions about their care, treatment and support.

Good

Is the service responsive?
The service was responsive.

Care files were personalised to reflect people's personal preferences, which were met with staff support.

There were regular opportunities for people and people that matter to them to raise issues, concerns and compliments.

Good

Is the service well-led?
The service was well-led.

Good

Summary of findings

Staff spoke positively about communication and how the registered manager worked well with them.

People's views and suggestions were taken into account to improve the service.

The organisation's visions and values centred around the people they supported.

A number of effective methods were used to assess the quality and safety of the service people received.

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 unannounced inspection took place on 8 December 2015. We returned on 11 and 15 December 2015 as arranged with the management team. This comprehensive inspection was brought forward in response to receiving information of concern about how people were spoken to by staff, a lack of incident reporting to the local authority safeguarding team, staff having limited access to care files and new staff receiving a poor induction when starting work at The Old Rectory. We were unable to substantiate these concerns during our inspection, apart from staff receiving a limited induction when starting work at the home and a lack of incident reporting. Our last inspection in December 2013 found the service to be meeting all of the Health and Social Care Act 2008 regulations inspected.

The inspection team consisted of one inspector.

Before the inspection, we reviewed the information we held about the home and notifications we had received. Notifications are forms completed by the organisation about certain events which affect people in their care.

We spoke with nine people receiving a service, three relatives and 10 members of staff, which included the registered manager.

We reviewed four people's care files, four staff files, staff training records and a selection of policies, procedures and records relating to the management of the service. Before our visit we sought feedback from health and social care professionals to obtain their views of the service provided to people. We received feedback from five health and social care professionals.

Good

Is the service safe?

Our findings

People felt safe and supported by staff. Comments included: "I could talk to anybody if I was worried about anything" and "I can talk to the staff." A relative commented: "I give thanks that X is here, I feel he is safe."

Staff demonstrated an understanding of what might constitute abuse and knew how to report any concerns they might have. For example, staff knew how to report concerns within the organisation and externally such as the local authority, police and to the Care Quality Commission. Staff records confirmed staff had received safeguarding training to ensure they had up to date information about the protection of vulnerable people.

The registered manager demonstrated an understanding of their safeguarding roles and responsibilities. They explained the importance of working closely with commissioners, the local authority and relevant health and social care professionals on an on-going basis. There were clear policies for staff to follow. Staff confirmed they knew about the provider's safeguarding adults' policy and procedure and where to locate it if needed. However, there were two incidents which had occurred in October and November 2015 involving a person physically abusing other people living at the service. These had not been referred to the local authority safeguarding team due to administrative errors at the time, as the management team were covering staff shortages in the home. At the time of the incidents, appropriate measures had been put in place, including debriefing staff. Safeguarding alerts were retrospectively referred to the local authority on 14 December 2015 as a result of raising the concerns with the management team during our inspection.

People's individual risks were identified and risk assessment reviews were carried out to keep people safe. For example, risk assessments for behaviour management, medicines, epilepsy and accessing the local community. Risk management considered people's physical and mental health needs and showed that measures to manage risk were as least restrictive as possible. For example, people had positive behaviour support plans in place for staff to follow if an incident occurred. A positive behaviour support plan is a document created to help understand and manage behaviour in adults who have learning disabilities and display behaviour that others find challenging. A relative commented: "Continuity of care has helped X to manage his behaviour."

Staff confirmed that people's needs were met promptly and felt there were sufficient staffing numbers. We observed this during our visit when people needed support or wanted to participate in particular activities. For example, staff spent time with people engaging in a range of activities both within the home and local community.

A member of the management team explained that during the daytime there were a minimum of six staff members on duty. At night there was one waking night staff and two further staff slept in and could be called upon if required. We asked how unforeseen shortfalls in staffing arrangements due to sickness were managed. They explained that regular staff and members of the management team would fill in to cover the shortfall, so people's needs could be met by the staff members that understood them. In addition, the service had on-call arrangements for staff to contact if concerns were evident during their shift. The on-call arrangements were shared between members of the organisation's management team.

There were effective recruitment and selection processes in place. Staff had completed application forms and interviews had been undertaken. In addition, pre-employment checks were done, which included references from previous employers and Disclosure and Barring Service (DBS) checks completed. This demonstrated that appropriate checks were undertaken before staff began work in line with the organisations policies and procedures. This was to help ensure staff were safe to work with vulnerable people.

People's medicines were managed so they received them safely. Appropriate arrangements were in place when obtaining medicine. The home received people's medicines from a local pharmacy on a monthly basis. When the home received the medicines from the pharmacy they had been checked in and the amount of stock documented to ensure accuracy.

Medicines were kept safely in a locked medicine cupboard. The cupboard was kept in an orderly way to reduce the

Good

Is the service safe?

possibility of mistakes happening. Medicines were safely administered. Medicines recording records were appropriately signed by staff when administering a person's medicines.

The premises were adequately maintained through a maintenance programme. Fire safety checks were completed by staff employed by the service and external contractors. For example, fire alarm, fire extinguishers and electrical equipment checks. Staff had received health and safety and fire safety training to ensure they knew their roles and responsibilities when protecting people in their care. People were protected because the organisation took safety seriously and had appropriate procedures in place.

Requires improvement

Is the service effective?

Our findings

Consent to care and treatment was not always carried out in line with legislation and guidance. People had Lasting Power of Attorneys for property and financial affairs. A Lasting Power of Attorney (LPA) is a way of giving someone a person trusts, the legal authority to make decisions on their behalf, if they are unable to at some time in the future. However, on one occasion a next of kin was consenting to care and treatment on a person's behalf without the legal authority to do so. For example, consenting to a person moving units at the service to help manage their escalating behaviour. For someone to make decision about care and treatment they need to be a LPA for health and welfare. Then they can make decisions about, for instance, where a person should live and medical care. This meant that consent was not being sought in line with the Mental Capacity Act (MCA) (2005). However, it should be noted that the person's behaviours had reduced since moving units and was calmer in the change of environment. Relatives felt the move was wholly appropriate and were happy with the outcome.

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

On other occasions, people's capacity to make decisions about their care and support were assessed on an on-going basis in line with the MCA. For example, where staff were concerned about a person's behaviour and their lack of capacity to make decisions and manage their emotions they had worked closely with other health and social care professionals. People's capacity to consent had been assessed and best interest discussions and meetings had taken place. For example, a best interest discussion had taken place about a person's behaviour. As a result a behaviour management plan had been formulated in consultation with professionals.

Before people received any care and treatment they were asked for their consent and staff acted in accordance with their wishes. Throughout our visit we saw staff involving people in their care and allowing them time to make their wishes known through the use of individual cues, such as looking for a person's facial expressions, body language and spoken word. People's individual wishes were acted upon, such as how they wanted to spend their time.

Staff demonstrated an understanding of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and how these applied to their practice. For example, what actions they would take if they felt people were being deprived of their freedom to keep them safe. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. The safeguards exist to provide a proper legal process and suitable protection in those circumstances where deprivation of liberty appears to be unavoidable and, in a person's own best interests. 11 people were subject to, or awaiting assessment for, DoLS at the time of our visit.

We received concerns staff did not have an adequate induction when they started work at The Old Rectory and we found this to be the case. Staff had completed an induction pack when they started work at the service. However, the induction did not include formal training. For example, safeguarding vulnerable adults. The management team explained that new staff were encouraged to bring in certificates from their previous employer to show they had received recent training. One new member of staff was observed to be lone working with one person whilst accessing the local community. They had completed the induction pack but had not received any formal training, including safeguarding vulnerable adults. We raised concerns that training should be provided by the service to ensure they were confident that new staff were competent to carry out their roles and safeguard people in their care. The management team agreed with us that this needed to improve and new members of staff were given workbooks to complete from a training company who specialised in training programmes in care. Any new staff were also to receive a week long induction which meant them completing both the induction pack and relevant training before working with people.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Part of the induction required new members of staff to be supervised by more experienced staff to ensure they were

Requires improvement

Is the service effective?

safe and competent to carry out their roles before working alone. This part of the induction enabled the organisation to assess staff competency and suitability to work for the service.

Existing staff who had been working at The Old Rectory for several years were trained to a level to meet people's current and changing needs. These staff received a range of training as part of a rolling programme, which enabled them to feel confident in meeting people's needs and recognising changes in people's health. They recognised that in order to support people appropriately, it was important for them to keep their skills up to date. Staff received training on subjects including, safeguarding vulnerable adults, the Mental Capacity Act (2005), behaviour management, autism awareness, epilepsy, communication and first aid. Staff had also completed varying levels of nationally recognised qualifications in health and social care. One staff member commented: "We get training to help us carry out our roles competently." The service was also in the process of implementing the new care certificate. The care certificate aims to equip health and social care staff with the knowledge and skills which they need to provide safe, compassionate care. Employers are expected to implement the care certificate for all applicable new starters from April 2015.

The organisation recognised the importance of staff receiving regular support to carry out their roles safely. Staff received on-going supervision and appraisals in order for them to feel supported in their roles and to identify any future professional development opportunities. Staff confirmed that they felt supported by the management team. Staff files and staff confirmed that supervision sessions and appraisals took place on both a formal and informal basis. Appraisals were structured and covered a review of the year, overall performance rating, a personal development plan and comments from both the appraiser and appraisee.

People did not comment directly on whether they thought staff were well trained. However, people were happy with the staff who supported them. One indirect comment included: "The staff take care of people, they are nice." A relative commented: "The staff are excellent, they communicate well together."

Staff knew how to respond to specific health and social care needs. For example, recognising changes in a person's physical or mental health. Staff spoke confidently about the care practices they delivered and understood how they contributed to people's health and wellbeing. For example, how people preferred to be supported with personal care. Staff felt people's care plans and risk assessments were really useful in helping them to provide appropriate care and support on a consistent basis.

People were supported to see appropriate health and social care professionals when they needed, to meet their healthcare needs. There was evidence of health and social care professional involvement in people's individual care on an on-going and timely basis. For example, GP, psychiatrist and hospice nurse. Records demonstrated how staff recognised changes in people's needs and ensured other health and social care professionals were involved to encourage health promotion. Health and social care professionals commented that staff were very good at contacting relevant professionals when they recognised changes in people's needs.

People were supported to maintain a balanced diet. People were actively involved in choosing the menu with staff support to meet their individual preferences. Care plans and staff guidance emphasised the importance of people having a balanced and nutritious diet to maintain their general well-being. Staff recognised changes in people's nutrition with the need to consult with health professionals involved in people's care. People's weights were monitored on a consistent basis to ensure their general well-being. People had been assessed by the speech and language therapist team in the past. Speech and language therapists work closely with people who have various levels of speech, language and communication problems, and with those who have swallowing, drinking or eating difficulties.

Good

Is the service caring?

Our findings

Prior to our inspection we received information about how people were spoken to by staff in an inappropriate manner. We were unable to substantiate these concerns during our inspection. We discussed these concerns with the registered manager and members of the management team. They were concerned these had been raised as they worked alongside the staff team on an on-going basis and had not witnessed inappropriate interactions. They added that they would have dealt with them as a matter of urgency. They could only recall one occasion when they had to speak with a member of staff about how they spoke with people and this had now been rectified through supervision.

Interactions between staff and people were good humoured and caring. Staff involved people in their care and supported them to make decisions. People's comments included: "I love living here"; "The staff are nice" and "I love my bedroom, look at my bed!" A relative commented: "The Old Rectory is fantastic, the best ever. They look after X very well. He is happy and relaxed. I can now relax, knowing he is well looked after." Another relative commented: "The care is second to none."

Staff treated people with dignity and respect when helping them with daily living tasks. One person commented, "I have my own bedroom with all my things in it." Staff told us how they maintained people's privacy and dignity when assisting with intimate care. For example by knocking on bedroom doors before entering, being discreet such as closing the curtains and gaining consent before providing care. Staff adopted a positive approach in the way they involved people and respected their independence. For example, supporting people to make specific activity decisions. People were completing a variety of activities and accessing the local community during our inspection.

Staff supported people in an empathic way. They demonstrated this empathy in their conversations with people they cared for and in their discussions with us about people. Staff showed an understanding of the need to encourage people to be involved in their care. For example, one person enjoyed staff talking to them about things of interest to them; this provided them with reassurance.

Staff were involving people in their care through the use of individual cues, and looking for a person's facial expressions, body language, spoken word and objects of reference. The service used a variety of communication tools to enable interactions to be led by people receiving care and support. For example, Makaton and pictures. Makaton is a language programme using signs and symbols to help people to communicate. It is designed to support spoken language and the signs and symbols are used with speech, in spoken word order. With Makaton, people can communicate straight away using signs and symbols.

Staff gave information to people, such as when activities were due to take place. We observed that staff communicated with people in a respectful way. Staff relationships with people were strong, caring and supportive. Staff spoke confidently about people's specific needs and how they liked to be supported. Staff were motivated and inspired to offer care that was kind and compassionate. For example, staff demonstrated how they were observant to people's changing moods and responded appropriately when a person was feeling anxious. They explained the importance of supporting them in a caring and calm manner by talking with them about things which interested them and made them happy. Staff recognised effective communication as an important way of supporting people, to aid their general wellbeing.

Staff showed a commitment to working in partnership with people. Staff spoke about the importance of involving people in their care to ensure they felt consulted, empowered, listened to and valued. Staff spoke of the importance of empowering people to be involved in their day to day lives. They were able to speak confidently about the people living at The Old Rectory and each person's specific interests. They explained that it was important that people were at the heart of planning their care and support needs and how people were at the centre of everything.

Good

Is the service responsive?

Our findings

People received personalised care and support specific to their needs, preferences and diversity. Care plans reflected people's health and social care needs and demonstrated that other health and social care professionals were involved.

Prior to our inspection we received information about staff having limited access to care files. We were unable to substantiate these concerns during our inspection. Care files gave information about people's health and social care needs. They were personalised and reflected the service's values that people should be at the heart of planning their care and support needs. For example, supporting people to identify specific activities to aid their wellbeing and sense of value.

Care files included personal information and identified the relevant people involved in people's care, such as their GP. The care files were presented in an orderly and easy to follow format, which staff could refer to when providing care and support to ensure it was appropriate. Relevant assessments were completed and up-to-date, from initial planning through to on-going reviews of care. Staff commented that the information contained in people's care files enabled them to support them appropriately in line with their likes, dislikes and preferences. Care files included information about people's history, which provided a timeline of significant events which had impacted on them, such as, their physical and mental health. People's likes and dislikes were taken into account in care plans. This demonstrated that when staff were assisting people they would know what kinds of things they liked and disliked in order to provide appropriate care and support.

Care plans were up-to-date and were clearly laid out. They were broken down into separate sections, making it easier to find relevant information, for example, physical and mental health needs, personal care, communication, social activities and eating and drinking. Staff confirmed they had access to care plans when needed and found them helpful. They were able to refer to them at times when they recognised changes in a person's physical or mental health.

Activities formed an important part of people's lives. People engaged in wide variety of activities and spent time in the local community going to specific places of interest. For example, swimming, shopping, pantomimes, the donkey sanctuary, college, meals out and for walks. People were encouraged to maintain relationships with their friends and family. For example, care plans documented the importance to people of seeing their family and friends. People's comments included: "I go to college four times a week" and "Pantomime and Christmas party today."

There were regular opportunities for people, and people that matter to them, to raise issues, concerns and compliments. This was through on-going discussions with them by staff and members of the management team. People were made aware of the complaints system. The complaints procedure set out the process which would be followed by the provider and included contact details of the provider and the Care Quality Commission. This ensured people were given enough information if they felt they needed to raise a concern or complaint. The service had not received any complaints. However, the registered manager recognised that if they received a complaint, they would attend to it in line with the organisation's procedure.

Good

Is the service well-led?

Our findings

Staff spoke positively about communication and how the registered manager worked well with them, encouraged team working and an open culture. Staff said, "We work as a team" and "The culture is open, sociable and we can have a laugh. I love it here."

Staff confirmed they had regular discussions with the management team. They were kept up to date with things affecting the service via team meetings and conversations on an on-going basis. Additional meetings took place on a regular basis as part of the service's handover system which occurred at each shift change.

People's views and suggestions were taken into account to improve the service. For example, resident meetings took place to address any arising issues and the registered manager ensured they spent time with people on a regular basis. For example, to identify particular activities and food choices. In addition, surveys had been completed by people using the service. The surveys asked specific questions about the standard of the service and the support it gave people. All comments received were positive. The registered manager recognised the importance of ever improving the service to meet people's individual needs. This included the gathering of people's views to improve the quality and safety of the service and the care being provided.

The service's vision and values centred around the people they supported. The organisation's statement of purpose documented a philosophy of maximising people's life choices, encouraging independence and people having a sense of worth and value. Our inspection found that the organisations philosophy was embedded in The Old Rectory.

The service worked with other health and social care professionals in line with people's specific needs. This also enabled the staff to keep up to date with best practice, current guidance and legislation. People and staff commented that communication between other agencies was good and enabled people's needs to be met. Care files showed evidence of professionals working together. For example, GP and hospice nurse. Regular medical reviews took place to ensure people's current and changing needs were being met. Health and social care professionals confirmed that the service worked well with them and took on board things requested.

There was evidence that learning from incidents and investigations took place and appropriate changes were implemented. For example, changes to a person's care plan and risk assessment to reflect current circumstances. Actions had been taken in line with the service's policies and procedures. Where incidents had taken place, involvement of other health and social care professionals was requested to review people's plans of care and treatment. The service was both responsive and proactive in dealing with incidents which affected people.

Checks were completed on a regular basis as part of monitoring the service provided. For example, the checks reviewed people's care plans and risk assessments, medicines, incidents and accidents and health and safety. This enabled any trends to be spotted to ensure the service was meeting the requirements and needs of people being supported. Where actions were needed, these had been followed up. For example, care plans reviewed and maintenance jobs completed.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Consent for care and treatment was not given in accordance with the Mental Capacity Act 2005. Regulation 11 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff did not receive a comprehensive induction when they started working for the service to enable them to carry out their duties they were employed to perform. Regulation 18 (2) (a)