Akari Care Limited

Felmingham Old Rectory

Inspection report

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Tel: 01692405889

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Felmingham Old Rectory is a residential care home that was providing personal care to 16 people aged 65 and over, and younger people, at the time of the inspection. The service can support up to 41 people. The home is an adapted period building set in its own grounds. Accommodation is over two floors.

People's experience of using this service and what we found
People remained at risk of avoidable harm through the provider's failure to consistently identify, assess, manage and mitigate risk. This included putting people at risk of abuse and receiving unsafe care. People did not receive their medicines as prescribed and this had resulted in harm.

The governance of the service remained ineffective. This was due to inconsistent and changing management and failure to promptly act on identified concerns. There was a lack of accountability on behalf of the provider and a failure to act promptly on long identified concerns. This had resulted in people receiving unsafe care that exposed them to the risk of avoidable harm.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection (and update)
The last rating for this service was inadequate (report published 6 June 2019) where nine breaches to regulations were found.

Shortly following our last comprehensive inspection in May 2019, the local authority terminated their contract with the service. This resulted in nine people being moved out of the service. At the time of this inspection in June 2019, urgent reviews were being undertaken of all other local authority placed people with the view of finding alternative placements for them.

Why we inspected
We received concerns in relation to the management of risk and the governance arrangements. As a result, we undertook a focused inspection to review the Key Questions of Safe and Well-led only.
We reviewed the information we held about the service since our last inspection in May 2019 which indicated we did not need to reinspect the other Key Questions of Effective, Caring and Responsive. Ratings from the previous comprehensive inspection for those Key Questions were used in calculating the overall rating at this inspection.
The overall rating for the service remains inadequate. This is based on the findings at this inspection. We found evidence that people were at risk of harm from these concerns. Please see the Safe and Well-led sections of this full report.
Following our inspection, the provider took some action to mitigate the risks found.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for

Felmingham Old Rectory on our website at www.cqc.org.uk.

Enforcement
At this inspection, we have identified breaches in relation to the safe care and treatment of people, the governance of the service and the provider's regulatory responsibilities.

Our findings at this inspection confirmed the actions we took following the comprehensive inspection completed in May 2019 where serious and widespread concerns were found. Following that inspection, we took urgent enforcement action to restrict admissions into the service. Further enforcement action was taken which cannot be reported on at this time.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will continue to closely monitor information we receive about the service, and work with partner agencies, until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Felmingham Old Rectory

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
Two inspectors, an inspection manager and a medicines inspector.

Service and service type
Felmingham Old Rectory is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. This means that the provider alone is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection on 1 and 3 May 2019. We sought feedback from the local authority and several professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. This information helps support our inspections. We took this into account when we inspected the service and made the judgements in this report. We used all this information to plan our inspection.

During the inspection
We spoke with six members of staff including members of the support team; a team the provider had brought in from another of their services to help drive improvement. We also spoke with the interim manager, the regional manager, an agency senior care assistant and a member of the care team. We also observed the care people received.

We reviewed a range of records. This included six people's care records and the medication records for 16 people. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. The provider submitted further evidence which we reviewed as part of this inspection.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as inadequate. At this inspection this key question remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 12 regarding risk management.

- Risks to people had not been consistently identified, assessed or mitigated.
- Our previous inspection in May 2019 identified accessible cleaning products and toiletries which posed a risk of accidental ingestion to people living with dementia. Since the inspection in May 2019, an incident had occurred where a person took a sip of a toiletry item. At this inspection in June 2019 we found several incidents where toiletries and cleaning products were not secure and so were accessible to people. The service had failed to ensure such products were secure and therefore mitigate the associated risks. This continued to place people at risk of harm.
- We found the kitchen to be accessible where several items posed a risk to people, particularly to those living with dementia. For example, knifes were found on worktops, large saucepans of boiling liquid were on gas burners and cleaning products placed on the worktops. In addition, a fire exit was blocked by a serving trolley.
- We found a heavy and laden wardrobe unsecure in one person's bedroom which was at risk of falling. The provider's guidance instructed that all wardrobes were to be fixed to the wall however they had failed to identify this as a risk and action accordingly.
- The service had failed to act promptly and appropriately to ensure one person was provided with medicine to manage and relieve constipation. This had resulted in the person becoming distressed and in discomfort.
- Whilst the service had requested support from other healthcare professionals regarding one person's escalating behaviour, they had failed to promptly assess, manage and mitigate the risks associated with it. This had resulted in several safeguarding incidents between the person and other service users.

The service's failure to assess, manage and mitigate risks to people placed them at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Using medicines safely

At our last inspection the provider had failed to safely manage and administer medicines. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 12 regarding medicines management.

● People did not have their medicines consistently administered safely, as prescribed or in line with good practice guidance.
● We could not confirm medicines had been given to people because of gaps and discrepancies on the Medicine Administration Records (MAR charts).
● Some medicines prescribed for external application, such as creams and emollients, were accessible to people which meant there was a risk of accidental ingestion. Medicines requiring refrigeration were not stored within the required temperature range and therefore were not safe for use.
● Guidance to help staff give people their medicines appropriately and safely when prescribed on a 'when required' basis was not consistently in place. Records regarding people's medicines allergies and sensitivities were sometimes inconsistent increasing the risk of error.
● The service had not assured themselves that all staff administering medicines were competent and safe to do so as one senior staff member's competency assessment was outstanding. Audits undertaken by the service had failed to identify and rectify errors and concerns relating to medicines administration and management.

The above concerns placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to protect people from the risk of abuse. This was a breach of regulation 13 (Safeguarding Service Users from Abuse and Improper Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 13.
● Systems to safeguard people from the risk of abuse remained ineffective.,
● Several safeguarding incidents regarding one service user had not been reported to the local authority safeguarding team as required. This put that person at risk of continuing abuse.
● Our last inspection in May 2019 identified that the provider had failed to investigate employment gaps for potential and employed staff to assure themselves of their suitability. At this inspection in June 2019, we found an employment gap for a staff member who had been alleged of a serious incident of abuse. Due to the provider's failure to explore this gap, they could not be fully assured that the staff member was safe and appropriate to work with those living at the service.
● There continued to be staff who had not received training in safeguarding adults.
The above concerns placed people at risk of abuse and improper treatment. This was a continued breach of regulation 13 (Safeguarding Service Users from Abuse and Improper Treatment) of the Health and Social Care Act 2008 (Regulated Activities) 2014.
Preventing and controlling infection

At our last inspection the provider had failed to implement procedures to prevent and control infection and

ensure the premises and equipment were clean, appropriately located and properly used. This was a breach of regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found some improvements had been made although concerns remained. The provider was no longer in breach of this regulation.

● Offensive odours continued to be present within the home.
● People continued to share moving and handling slings. However, we observed that decontamination took place in between use.
● The home continued to have only one hoist available to people. However, due to several people having recently moved out of the service, this had less of an impact on its availability when required. A second hoist had been purchased but was not in use at the time of the inspection as staff were awaiting training to use it.
● Some staff who operated the hoist continued to be untrained in the use of this equipment.
● The home appeared visibly cleaner than our inspection in May 2019 however we did note one toilet smeared in faeces during this inspection in June 2019.

Staffing and recruitment
● We observed enough staff deployed within the home to meet people's needs.
● The provider used a dependency tool to ascertain staffing levels according to people's needs and this had been used to determine staffing levels. We viewed the staffing rotas and compared these to the provider's most recent staffing assessment. We saw that the assessed levels of staff had been consistently on shift.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as inadequate. At this inspection this key question remained the same.

Inadequate: This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection the provider had failed to operate systems to ensure effective governance. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 17.

Continuous learning and improving care; Working in partnership with others

- The serious instability of the management team had continued since our last inspection contributing to the ineffective monitoring of the service. The interim manager who had been employed during our inspection in May 2019, was no longer in post at this inspection; a further interim manager had been employed.
- Quality monitoring checks continued to be ineffective at identifying and promptly rectifying concerns. For example, room checks had failed to identify potentially unsafe furniture.
- Health and safety concerns that had been identified at our previous inspection, and by an audit completed by the provider since this inspection, were still outstanding at this inspection completed in June 2019. Insufficient action had been taken to address these concerns. For example, inaccurate recording of environmental checks and the risks these posed remained as did a lack of staff training.
- A fire risk assessment had been carried out on the service on 3 May 2019 following our previous inspection. Required actions had been identified through this which were still outstanding at the time of this inspection. For example, insufficient action had been taken to ensure fire exits were not obstructed and flammable materials were managed safely.
- The provider had failed to undertake actions and meet their own specified deadlines for improvements documented within their home development plan. For example, medicine PRN protocols were still outstanding as were medicine competency assessments for all senior staff. The home development plan recorded that both these should have been completed by 15 and 25 May 2019 respectively.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- At the time of this inspection no manager was registered with the CQC as required by the provider's registration.

● Despite receiving assurances from the provider that adequate management was in place from 9am until 5pm each day, no manager was on site till approximately 2pm on the day of our inspection.
● We had concerns about the lack of accountability of the provider and their inability to retain a consistent manager. The provider attributed the ongoing concerns and lack of improvement to the recent service managers. However, the provider had failed to have adequate oversight of the service and the competency of their appointed managers.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Since our last inspection the service had taken some action to improve the culture of the home including the dismissal or suspension of some staff. A staff member told us this had improved the culture of the home and our observations confirmed this. However, we could not be confident that the improvements had been fully embedded.

The provider had continued to fail to ensure systems were in place to achieve good governance. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● Since our last inspection in May 2019, the local authority had terminated their contract with the provider. The service had worked in partnership with the local authority regarding this and informed staff, those people that used the service and their relatives.
●The provider has sought feedback on the service from those that used it and others.

●The service had not ensured incidents had been reported appropriately to relevant stakeholders, this included the local authority safeguarding team and CQC, or failed to report to both.

Failure to report incidents to CQC constituted a breach of regulation 18 (Notification of Other Incidents) of the Care Quality Commission (Registration) Regulations 2009

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● Whilst the service had not fully engaged with people on an ongoing basis, when individual incidents had occurred, people and their relatives had been made aware.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents How the regulation was not being met: The provider had failed to notify CQC of all incidents that affect the health, safety and welfare of people who use services. Regulation 18 of the Care Quality Commission (Registration) Regulations 2009

The enforcement action we took:

Notice of Decision to restrict admissions and Notice of Decision to remove location (action taken following inspection on 3 May 2019).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: The provider had failed to assess, manage and do all that is reasonably practicable to mitigate the risks to the health and safety of service users of receiving care or treatment. Medicines management and administration was unsafe and failed to adhere to current legislation and guidance. Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The enforcement action we took:

Notice of Decision to restrict admissions and Notice of Decision to remove location (action taken following inspection on 3 May 2019).

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 13 HSCA RA Regulations 2014

personal care	Safeguarding service users from abuse and improper treatment How the regulation was not being met: Systems and processes had failed to protect people who used the service from abuse and improper treatment. Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The enforcement action we took:

Notice of Decision to restrict admissions and Notice of Decision to remove location (action taken following inspection on 3 May 2019).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met: Systems and processes had failed to protect people who used the service from abuse and improper treatment. Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The enforcement action we took:

Notice of Decision to restrict admissions and Notice of Decision to remove location (action taken following inspection on 3 May 2019).