Review of compliance

Adiemus Care Limited The Old Rectory	
Region:	East
Location address:	Spring Lane Lexden Colchester Essex CO3 4AN
Type of service:	Care home service without nursing
Date of Publication:	April 2012
Overview of the service:	The Old Rectory provides accommodation with personal care for up to 60 older people. Some people who use the service may have dementia.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

The Old Rectory was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review because concerns were identified in relation to:

Outcome 04 - Care and welfare of people who use services
Outcome 09 - Management of medicines
Outcome 13 - Staffing

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 9 March 2012, talked to staff and talked to people who use services.

What people told us

People told us that they liked living at The Old Rectory and the staff were kind and caring. People said they didn't have any complaints as the staff did their best. People could decide when they got up and went to bed but sometimes they had to wait for help. Relatives told us that there had been a lot of staff changes lately and sometimes they didn't see many staff around which concerned them.

What we found about the standards we reviewed and how well The Old Rectory was meeting them

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

The provider is not compliant with this outcome. People cannot be assured that they received care and support that meets their individual needs when and in a way they require it.

Outcome 09: People should be given the medicines they need when they need them, and in a safe way

The provider is not compliant with this essential standard. People cannot be assured that medicines are stored safely and securely. There is insufficient guidance for staff on the

use of some medicines.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs

The provider is not compliant with this outcome. People were not supported by sufficient numbers of skilled care staff all of the time.

Outcome 17: People should have their complaints listened to and acted on properly

The provider is not compliant with this outcome. Whilst people using the service and their relatives could expect their complaints to be listened to and acted upon they were not recorded appropriately in order for the service to monitor improvements.

Actions we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

There are moderate concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
Some people could tell us that they liked living at The Old Rectory. They said it was warm and friendly, the food was good and they had a choice of what they had for their lunch and dinner. One person told us that they had been waiting to get up for a long time and that nobody had come. Relatives told us that the staff were kind and cared for people.

Other evidence
On our visit of 09 March 2012, we saw that some people who used the service had their own daily diaries with them, with a large photo of themselves on the front. This was so that details could be recorded easily for people whose needs require regular supervision and support. People liked having their diaries with them.

Since our last visit in January 2012, the care plans had been moved to an office from an open plan area so they were kept more secure. However, this office was consistently open so that care plans were not kept securely. Also when staff were updating the care plans they were left in a pile on the floor in the communal area. This does not ensure that people's personal details were kept confidential.

In response to concerns about people's care and welfare, we spent time talking to people and observing them in the communal areas. We saw that some people were in the lounge areas and people were chatting over breakfast in the dining room. People were well dressed and comfortable. We saw an activity going on in one of the lounges where people were involved and enjoying themselves.

Some people were in their bedrooms, some dressed and watching the TV, others still asleep and some people waiting to get up after 10.30am. One person we saw in their bedroom looked uncomfortable and told us they had been waiting a long time to get up. The staff we talked with told us that people do have to wait to get up as there were only two of them on in each area of the home (there were three areas known as floors) for between 10 and 15 people and some people needed two staff to assist them.

A number of people needed assistance with eating their meals. The meal times were staggered and people who relied solely on staff to help them have their meals were given them first. This enabled the staff to assist some people to eat and then serve up the meals for other people who did not need help. We saw people being assisted in the lounge instead of the dining room and were told that if people took a long time to eat they had to feed them instead of helping them eat. This did not ensure a person centred approach and took away those people's dignity.

We were told that five people had risk assessments for pressure care and all had air mattresses and cushions and were assisted to move every two hours to ensure they were kept comfortable and free of pressure sores.

Our judgement
The provider is not compliant with this outcome. People cannot be assured that they received care and support that meets their individual needs when and in a way they require it.

Outcome 09:
Management of medicines

What the outcome says

This is what people who use services should expect.

People who use services:
* Will have their medicines at the times they need them, and in a safe way.
* Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

Our judgement

There are moderate concerns with Outcome 09: Management of medicines

Our findings

What people who use the service experienced and told us
On this occasion we did not speak to anyone who uses the service about the way the home manages their medicines.

Other evidence
Since our last review we had received information which raised concerns over the management of medicines within the home.

On this visit of 09 March 2012 we found that medicines were not stored securely for the protection of people who use the service. The trolleys used to store medicines were in public areas and were not secure. We found a cream prescribed for one person in a communal bathroom. This could increase the risk of cross infection if used for the treatment of a person other than the person it was prescribed for. We also found that the fridge used to store medicines contained a pathological sample which is not an acceptable place to store such material. The temperatures of the areas where medicines were stored were not all being monitored and recorded regularly to demonstrate the quality of medicines in use. The cupboard used to store controlled drugs was not fixed to the wall in the way required by the regulations.

Procedures were in place to record when medicines were received into the home, when they were given to people and when they were disposed of. In general these were in order and demonstrated that people received their medicines as prescribed. But where medicines were given at different times to those on the printed medication record forms,

the actual time it was given was not recorded and this could result in people receiving medicines too close together. In some cases the name of the medicine on the label of the container was a different name to that on the printed medication record. For one person medication was omitted as it was out of stock for a period of five days.
We had received information that medicines were not being disposed of correctly or in accordance with the service's procedure. We did not find any evidence to substantiate this.

Where people were prescribed medicines on a "when required" basis, for example, for pain relief or to control a person's behaviour which was challenging the service, there was guidance for staff on the circumstances these medicines are used. But in some cases this guidance was inadequate to ensure the medicines were used appropriately. In one case the daily records did not support the use of a medicine to control behaviour.

Our judgement
The provider is not compliant with this essential standard. People cannot be assured that medicines are stored safely and securely. There is insufficient guidance for staff on the use of some medicines.

Outcome 13:
Staffing

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement

There are moderate concerns with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
Some people were able to tell us what they thought of the care they received from staff. Those that did said that the staff were caring and kind. People could decide when they got up and went to bed but sometimes they had to wait for help. One person said "All I see is new faces - what happened to X, did they leave?" Relatives told us that there had been a lot of staff changes lately and sometimes you don't see the staff around much.

Other evidence
We had received concerns in March 2012 regarding the level of staffing at The Old Rectory.

At our last inspection in January 2012, we were told that shift patterns had changed to provide more time for administering medication and that the numbers of staff had increased which had benefitted people who used the service and staff.

However, the numbers of staff had since been reduced and the rota showed us that six care staff and two senior care staff covered the day and evening shift from 7.30am to 2.30pm and 2.30pm to 9.30pm to care for 36 older people, some of whom had dementia. The service offered staff to work a long day which was a 14 hour shift with a one hour break. The staff told us this was a good idea but it was very long and tiring and they were not at their best at the end of the shift especially if they were also doing an early shift the next day. The activities coordinators also assisted people at lunchtimes. Four staff covered the night shift from 9.30pm to 7.30am.

There had been a high turnover of staff since December 2011 and 11 new staff had been recruited. Agency staff had also been used to cover for sickness and holidays. We were told that new staff were very welcomed, but there was no extra support to train them up and support them on top of the usual caring duties.

The deputy manager told us that at least half of the people living at The Old Rectory needed two staff to assist them with their personal care when using a hoist to transfer from one place to another. The staff told us that this meant sometimes leaving people using the service, especially those with dementia, without support or supervision for a period of time and they could be at risk. Some staff felt that more time should be allocated to the staff working with people with dementia so that they had a better quality of staff care.

Internal and external support for the management of the home had been increased since our last inspection. However, management roles and responsibilities needed to be clarified to ensure effective communication and consistency with the staff to enable them to do their job well.

We had asked The Old Rectory at the inspection in October 2011 to look at finding a way of working out how many staff were needed to adequately meet the needs of people at the service. We were told this was in progress. Due to the concerns we had received, the feedback from staff and some people who use the service and relatives during our visit on 09 March 2012, it was essential that this was done as quickly as possible to ensure people were not at risk of harm or neglect.

Our judgement
The provider is not compliant with this outcome. People were not supported by sufficient numbers of skilled care staff all of the time.

Outcome 17:
Complaints

What the outcome says

This is what people should expect.

People who use services or others acting on their behalf:
* Are sure that their comments and complaints are listened to and acted on effectively.
* Know that they will not be discriminated against for making a complaint.

What we found

Our judgement

There are minor concerns with Outcome 17: Complaints

Our findings

What people who use the service experienced and told us
Some people we spoke with told us that they didn't have any complaints as the staff did their best. Some relatives had concerns about staffing levels and the turn over of staff.

Other evidence
We saw two complaints in the file that had been recorded and dealt with effectively.

However, we were told about a further three complaints that had been made in January and February 2012 regarding concerns about people's care and welfare that were not recorded in the complaints book. We were told that these had been dealt with and updates about people's care had been written in the daily notes. However, there was no written record of actions taken or outcomes in the complaints book.

The home must ensure that complaints about the care and welfare of people using the service should always be recorded together with the actions taken and all correspondence relating to the matter. The deputy manager agreed to record these complaints and actions by following the correct procedure.

Our judgement
The provider is not compliant with this outcome. Whilst people using the service and their relatives could expect their complaints to be listened to and acted upon they were not recorded appropriately in order for the service to monitor improvements.

Action
we have asked the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: People cannot be assured that they received care and support that meets their individual needs when and in a way they require it.	
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines
	How the regulation is not being met: People cannot be assured that medicines are stored safely and securely. There is insufficient guidance for staff on the use of some medicines.	
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	How the regulation is not being met: People were not supported by sufficient numbers of skilled care staff all of the time.	
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 17: Complaints

	How the regulation is not being met: Whilst people using the service and their relatives could expect their complaints to be listened to and acted upon they were not recorded appropriately in order for the service to monitor improvements.

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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