Pearlcare (Acle) Limited

The Old Rectory Care Home

Inspection report

Norwich Road
Acle
Norfolk
NR13 3BX
Tel: 01493 751322
Website: www.pearlcare.co.uk

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Ratings

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

Overall summary

This inspection was unannounced and took place on 2 September 2015.

The Old Rectory care home is a service that is registered to provide accommodation and care to up to 34 older people, some of whom are living with dementia. On the day of our inspection, there were 30 people living at The Old Rectory.

There was no registered manager working at the service. The registered manager had resigned from their post in March 2015. A new manager had started working for the service shortly after this date but they had resigned a month prior to our inspection. The provider was interviewing for a new manager on the day of the inspection. 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.

At this inspection we found that the provider was in breach of three regulations of the Health and Social Care

Summary of findings

Act 2008 (Regulated Activities) Regulations 2014. These related to failures to provide safe care and treatment, to monitor the quality of the service provided effectively and to make sure there were enough staff working who had received the required training to keep people safe and meet their needs. You can see what action we told the provider to take at the back of the full version of the report.

Some risks to people's health and safety were not being managed well and there were not always enough staff in place to meet people's individual needs. The provider could not clarify whether staff had received enough training to provide them with the knowledge and skills to meet people's needs and people's medicines were not managed safely.

People were asked for their consent before the staff provided them with care. However, there was a risk that those people who were unable to consent to their own care were not always having their rights protected. Some people were not always treated with dignity and respect.

There were activities on offer to complement people's hobbies and interests but some people were not protected from the risk of social isolation.

The provider had not effectively monitored the quality of the service to make sure that people received safe and appropriate care and there was currently a lack of clear leadership in place.

People and relatives felt confident to complain if they wanted to but were not sure who they needed to complain too.

People were protected from the risk of abuse and the staff were polite and courteous to people when they provided them with care.

People received enough food and drink to meet their needs and saw other healthcare professionals such as GP's and nurses when they needed to.

We have made recommendations regarding following the principles of the Mental Capacity Act 2005 when making best interest decisions on behalf of people.

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 safety had not always been assessed or reviewed.

There were not enough staff to meet people's needs and people's medicines were not managed safely.

The premises were well maintained and the equipment people used was safe.

The provider had systems in place to protect people from the risk of abuse.

Requires improvement

Is the service effective?
The service was not consistently effective.

It was unclear whether staff had received enough training to enable them to provide people with effective care.

Staff did not have a good understanding of how to apply the principles of the Mental Capacity Act 2005 to protect the rights of those people who were unable to consent to their own care.

People had access to plenty of food and drink.

Staff supported people with their healthcare needs.

Requires improvement

Is the service caring?
The service was not consistently caring.

The staff were observed to be polite and courteous when speaking to people, but some people were not treated with dignity and respect.

People and their relatives felt involved in making decisions about the care that was received.

Requires improvement

Is the service responsive?
The service was not consistently responsive.

People's care needs and preferences had been assessed but these had not always been regularly reviewed.

The activities on offer did not meet the needs of people who were at risk of social isolation.

People and their relatives felt confident to complain but did not know who to complain to. There was a system in place to investigate into people's complaints when they were made.

Requires improvement

Is the service well-led?
The service was not consistently well-led.

Requires improvement

Summary of findings

The provider had not effectively monitored the quality of the service being provided.

Due to a lack of manager working at the service, there was no clear leadership in place.

People were asked for their views on the care they received and their suggestions for improvements were acted on.

The Old Rectory Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 2 September 2015 and was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed information that we held about the service. Providers are required to notify the Care Quality Commission about events and incidents that occur including unexpected deaths, injuries to people receiving care and safeguarding matters. We reviewed the notifications the provider had sent us and additional information we had requested from the local authority safeguarding and quality assurance teams.

On the day we visited the service, we spoke with five people living at The Old Rectory, three visiting relatives, five care staff, the cook and the regional manager of the provider. Some people were not able to communicate their feedback to us and therefore, we observed how care and support was provided to some of these people. To do this, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

The records we looked at included five people's care records and other records relating to their care, five staff recruitment files and staff training records. We also looked at maintenance records in respect of the premises and equipment and records relating to how the provider monitored the quality of the service.

Requires improvement

Is the service safe?

Our findings

We found that risks to people's safety had not always been assessed or regularly reviewed and that actions that had been identified to reduce the risk had not always been taken.

The regional manager told us that the risks associated with people not eating and drinking enough should be assessed each month. This was so the provider could monitor whether the actions that were being taken to protect people were effective. However, we found that this was not the case. Of the five people's records we checked, we found that this risk to four people had not been assessed within this time frame. One person had not been formally assessed since November 2014 and another person since February 2015. One of the actions identified to mitigate this risk was to weigh people each month but this had not taken place. Two of these people who had been assessed as being of a low Body Mass Index in November 2014 and April 2015, had not been weighed since June 2015.

Three people had been assessed as being at either high or very high risk of developing pressure sores. Two of these people's risks had not been reassessed since April 2015. We found that another person who was immobile, had not had their risk of developing a pressure sore assessed at all.

According to their care records, two of these people who were being looked after in bed should have been re-positioned every two hours. However, records for three days prior to our inspection stated that one person had not been re-positioned for four hours on one occasion and for three hours on three separate other occasions. The other person's records stated that they had not been re-positioned for over seven hours on one occasion and over three hours on another the day before our inspection. It was stated within this person's care record that they had developed blisters on their sacrum which were now being treated by a district nurse. We asked staff about this to clarify if they were re-positioning people as they should have been. We received a mixed response from the staff. Some told us that they were but were not recording it within the records but others said that they were not able to re-position people due to a lack of time.

We also found that an area of the service posed a potential risk to people's safety. One of the communal toilets had an unlocked cupboard that contained a hot water tank and very hot pipes. The cupboard was closed but not locked and therefore people who lacked capacity to understand the dangers of these pipes were at risk.

This was a breach of Regulation 12, 1 and 2 a, b and d of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People's medicines were not being managed safety. They were stored securely within a locked room however, on the day of the inspection the temperature of this room was above 25C. This is above the recommended temperature and meant that there was a risk that the medicines could be unsafe to give to people. We saw that for a number of days prior to the inspection, this temperature had been exceeded. We asked a member of staff what action had been taken in response to this. They told us that a fan had been used to cool the room but that this had now broken. No replacement fan had been sought.

When people were prescribed medicines on a when required basis, there was a lack of written information available to show staff how and when to administer these medicines. Therefore people may not have had these medicines administered consistently and when appropriate. The regional manager advised that the required written information was currently being worked on. We also found that not all medicine records contained a photograph of the person which is good practice to help staff identify that they are giving the medicine to the correct person.

Staff were not recording the time they were giving people pain medicines. Therefore there was a risk that an adequate gap between doses would not be taken into account. Medicines such as eye drops, that usually should be used within 30 days, did not have the date they had been opened noted on them to help staff easily identify when they needed to be replaced. A staff member told us that this should be done to prevent the risk of giving them to a person when they had expired.

This was a breach of Regulation 12, 1 and 2 g of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We looked at what information there was available to assist staff when administering medicines to individual people. We found that people's allergies/medicine sensitivities had been recorded. There were charts in place to record the application and removal of medicated skin patches to treat people's pain and body maps to indicate where these

Is the service safe?

patches had been applied in line with best practice. Body maps were also in place to give staff clear guidance on where they needed to assist people to apply creams. When medicines were given to people, we saw that this was given to them correctly. Staff told the person what the medicine was and stayed with them to make sure that they had taken it.

The medicine records indicated that people received their oral medicines as intended by the person who prescribed them. However, the records for the administration of creams were incomplete. We asked the staff about this. They told us that they were applying creams as required but were not always updating the records.

People and relatives we spoke with told us that there were not always enough staff to meet their needs and that they sometimes had to wait for assistance. One person told us that there were only three staff working on 31 August 2015 which meant that they received their lunch late in the day. We were advised the same thing by a relative who told us, "Over the bank holiday there was hardly any staff. There were no drinks by 11am as they were still sorting out breakfast. You can't knock the staff. There's too few staff with too much to do." They added, "My relative needs two carers for the hoist for the toilet. When we're visiting we ring the bell but no-one comes. She can't wait for them to come so she wets the pad." Another person told us, "There were not quite enough staff here last week but they are not slow overnight." Another relative told us how they had provided assistance recently by taking some drinks to the people who lived at the service as no tea trolley had been brought around. This in itself was a risk as the relative may not have been aware that some people required their drinks to be thickened to prevent them choking on their drink.

Another person told us, "There's not quite enough staff, they're slow on the buzzers because they're busy." They went on to tell us "They [the staff] have told me I can only have two visits during the night. I get told on the second visit, this is your lot for the night. I need the loo as I have to drink a lot because of my circulation and I end up lying in wet." A relative of another person who lived at the service told us independently that their family member had raised the same concern with them. We have referred these matters to the local authority safeguarding team.

We received mixed views from four of the staff who had worked at the service long enough to comment on staffing levels. Two told us that there were enough of them to meet people's needs. However, the other two staff told us that they were 'stretched' at times which meant that they could not always assist people in a timely way.

We observed that there were not always enough staff to keep people safe or meet their needs in a timely manner. During lunchtime, one person was left unattended in a communal lounge for 20 minutes. We found that this person had been assessed in March 2015 as being at a high risk of falls and the regional manager told us that this person had fallen in the communal lounge two weeks ago. As no staff were monitoring this person the risks to their welfare were increased. Due to no staff entering the lounge area, this person's dignity was left unchecked as they had their clothing around their thighs which meant that their underwear was showing.

A number of people who had been taken into the dining room for their lunch at 12pm, had to wait until 12.50pm before this was received. One member of care staff who was taking hot drinks around to people was interrupted from doing this as they were asked by another carer to help them assist someone with personal care. This meant that people had to wait before they received a hot drink.

The regional manager told us that the current staffing levels were five staff in the morning, four staff in the afternoon and three at night. We looked at 24 days of staffing cover from 10 August to 2 September 2015. We found that on four occasions the required staffing levels were not met in the morning, on two occasions in the afternoon and on two occasions during the night. This included the recent bank holiday where only three staff had worked both in the morning and afternoon.

The regional manager told us that the staffing levels had recently increased on both the day and night shift due to resident feedback that there was a lack of staff working at the service. The staffing levels were calculated based on the regional manager's observations of the care that was required. No formal assessment tool was used to calculate how many staff were needed based on people's individual needs. The regional manager advised that a 'dependency tool' was used within the provider's other homes but this had not been done at this service. Therefore, the service may not have had the right number of staff on each shift to

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Is the service safe?

meet people's care needs all of the time. The regional manager agreed that the provider's 'dependency tool' would be implemented at this service to make sure that the staffing levels were adequate.

This is a breach of Regulation 18 1 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff shortages due to holiday or sickness were covered by existing staff or agency staff. The regional manager advised that they had tried to recruit a bank of staff who they could call upon when needed but that they had not received any applications for this. On the day of the inspection, two staff working at the service had been asked to cover from another of the provider's homes. Staff who worked in other roles such as domestics had also been trained in care so they could help out when needed. The regional manager told us that recruitment was currently a challenge for the service although they had managed to recruit some new staff recently. There remained one vacancy for a member of night staff and another vacancy to cover day shifts that they were actively recruiting for.

Most of the staff who were newly recruited to the service had been checked to make sure that they were of good character and safe to work with older people. However, we found that one staff member had left the service for one month to work for another care provider before returning to this service. The provider had not requested a reference from this care provider to ascertain the reason for the staff member leaving to make sure that it was for acceptable reasons.

Risks in relation to the premises had been assessed including fire and Legionella. We saw that actions had been identified to reduce any risk and that these were being completed. For example, checks of the water system were taking place each week to make sure that the water was safe.

We observed the premises to be well maintained. The fire exits were clear and well signposted. Records confirmed that the fire alarm system and equipment was tested regularly. Lifting equipment used to assist people to move had also been serviced regularly to make sure that it was safe to use.

All of the people we spoke with told us that they felt safe. One person said, "I feel safe and comfortable, the carers are very good." A relative told us, "[Family member] is safe here, in fact she told me so this morning she feels safe."

All of the staff we spoke with knew how to protect people from the risk of abuse. They understood the different types of abuse that could occur and how to report any concerns. We saw that any safeguarding issues at the service had been reported to the relevant authorities and had been thoroughly investigated by the provider where appropriate. We were therefore satisfied that the provider had taken steps to protect people against the risk of abuse.

Requires improvement

Is the service effective?

Our findings

People who lived at the service gave us mixed views about whether they felt the staff were well trained. Most people told us that they felt the levels of staff knowledge was sufficient to assist them but they added that they were concerned about the number of different staff who kept coming to work for the service. One person said, "I think some of them are trained but they don't stay for long enough." Another person told us, "They're trained well but they can't do two jobs at once."

A relative told us that they did not feel that the agency staff were very well trained. They said, "One of the agency staff attached an inflatable cushion incorrectly to [family member's] wheelchair and [family member] fell out, it's not good enough. In my view some of the agency staff leave a lot to be desired". They added, "Those that have been here a long time are very good." Another relative told us, "I don't think the training is that good, I think most of its in-house."

Some of the staff we spoke with told us they felt they needed more training to enable them to care for people effectively. One staff member told us they had not received any refresher training for some time, although they could not recall exactly how long this had been. Another said they had not had any training in subjects such as the Mental Capacity Act 2005 or dementia, even though approximately half of the people who resided at the service were living with dementia.

We asked staff if their competency regarding their training had been assessed. They told us that they could not recall whether it had been or not. One staff member told us that their competency to provide people with their medicines had not been reviewed.

The service had a training matrix that detailed the training that staff had received. We saw that some staff had received recent training in medication management, fire safety and catheter care. However, there were a number of gaps on the matrix which showed that staff had not received the required training. The regional manager advised us that they thought the staff had received training in a number of subjects but they were not able to provide us with any evidence of this. They were currently working on updating the matrix so they would have a clear picture of what training staff required. We could therefore not be assured that the staff had the relevant skills or up to date knowledge to provide people with safe and effective care.

Some staff told us that they had not had any recent supervision meetings. We noted that the provider had stated on the supervision documentation that supervions should take place every six weeks. However, in the staff files we checked, we found that only two supervision meetings had taken place in July 2015 for two staff. We were not provided with evidence that any other supervisions or appraisals had taken place with the staff to discuss their performance.

This was a breach of Regulation 18, 2 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

There were a number of people who lived at the service who lacked the capacity to make their own decisions about the care they received. This meant that the provider had to work within the principles of the Mental Capacity Act 2005 and the associated Deprivation of Liberty safeguards (DoLS). The majority of staff we spoke with did not have a good knowledge of how to support people who lacked capacity to make decisions for themselves and were not aware of the principles of the MCA and DoLS. Staff told us that they could not recall receiving training on this subject.

Assessments of people's capacity had been made and were in people's care records. However, these were general in nature and did not detail how staff should support people to make certain decisions about their care, although from our conversations with staff it was evident that they were doing this.

Decisions that required consent because they could restrict people's freedoms, such as placing pressure mat sensors by people's bed, had not been made following the principles of the MCA. Where there was doubt that the person could consent to this, no assessment of their capacity had been made. There was no evidence that a discussion had taken place with individuals who were involved in this person's care such as a relative, friend or healthcare professional to make sure that it was in their best interests to have a bed sensor in place which could detect their movements.

We also found that relatives had often given consent to people's care where it was felt that the person may not be

Is the service effective?

able to consent themselves. Relatives are not able to consent on behalf of the person who lacks capacity to do this themselves, unless they have been given legal authority to do so, such as through a Power of Attorney.

We have concluded that the principles of the MCA were not always being followed when providing care to people who lacked capacity to make decisions for themselves and that improvements are required within this area.

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The regional manager was aware that they may be depriving some people of their liberty in their best interests. They had therefore recently made some applications to the local authority for authorisation to deprive these people of their liberty. They were awaiting the outcome of these. Therefore the regional manager was aware of the DoLS legislation and what action had to be taken for the service to be acting lawfully.

Staff asked people for their consent before performing a task. For example, one staff member asked a person if they could give them their medicine. Another staff member asked someone if they could assist them into the lounge area. During lunchtime, people were asked if they wanted help to cut up their food so it was easier for them to eat.

People told us they had access to plenty of food and drink and that they liked the food. They also told us that the staff knew their likes and dislikes. One person said, “Yes, I get a choice of food. They know I’m allergic to strawberries”. We saw that this person received their dessert without strawberries. Another person told us, “I can only eat meat now if it is minced up, not cut up, minced up. I have had minced corned beef and they minced up a sausage, both were very good.” A relative told is, “They’re [the staff] are very obliging with food. They say tell us what [family member] likes and we’ll do it.”

Staff offered people drinks regularly throughout the day and there was water and various flavours of squash for people to help themselves to. However, we did see that one person only took a few sips of drink before leaving it and they were often seen with a full glass of drink. We checked this person’s care record which stated that they were able to drink independently. We told the regional manager about our observations and they agreed to review this person’s needs in relation to drinking to make sure that they did not require prompting by staff.

During the lunchtime meal, people were observed to enjoy the food. There was a choice of main meal and alternatives were offered if they did not like anything on the menu. One person who asked for a sandwich at lunchtime was told that a warm meal would be saved for them if they wanted it later on in the evening.

People who required specialist diets received them. The cook was aware how to prepare these meals and told us that the communication between them and the care staff was good. Therefore they were aware of how some people required their food. People who needed to have their drinks thickened because they were at risk of choking also received this. Staff were observed to help people who required assistance with their food and prompted others to eat a little more if they had not cleared their plate.

Where there were concerns about people eating and drinking enough, this had been referred to the person’s GP. Advice had been given and we saw that some people were receiving supplements to help them maintain a healthy weight.

People told us that staff supported them to maintain their health and we saw that referrals were made to healthcare professionals quickly when concerns about people’s health had been identified. One person told us, “The district nurse comes in to dress my leg.” Another person told us, “Yes, they will organise for a doctor or nurse fairly quickly.” Staff confirmed that the GP visited regularly when required. Visits were also made by other healthcare professionals such as the continence advisor, district nurse, chiropodist, dentist, occupational therapist and optician to provide people with assistance with their healthcare needs. We were therefore satisfied that people were supported by the staff to access assistance with their healthcare needs.

We recommend that the service considers current guidance in relation to assessing people’s consent in line with the principles of the MCA 2005 so make sure that people’s rights are protected.

Requires improvement

Is the service caring?

Our findings

Most people told us that the staff treated them with dignity and respect. One person said, "They [the staff] wash me in my bedroom and always cover me up. They're careful with my privacy and very respectful." Another person told us, "The staff respect people here" but they went on to add, "I have found that agency staff talk amongst themselves." Their relative qualified this by saying, "I've known agency staff to talk over [family member]."

We found that people were not always treated with dignity and respect. During our conversation with one person, they told us that the night staff had left them lying in a wet bed after they had called for assistance. A relative told us the same concern had been reported to them by their family member. We observed one person who was in their room had encrusted food down the front of their clothes which were not changed. This person's room also had an unpleasant odour of urine.

Although most staff knocked on people's doors before entering their room, not all of the staff did this, with some of them just walking straight into the person's room. We also observed one staff member call out to another during lunchtime, 'she's a soft diet' indicating that one person in the dining room required a specialist diet. This was done in front of a number of other people seated within the dining room.

People's care records were kept within a cupboard in the staff room. However, both the cupboard and door to this room were not lockable. Therefore, there was a risk that visitors to the service could access people's confidential records. This did not promote people's privacy. A staff member told us that a lock was due to be fitted onto the door imminently.

People who lived at the service were offered a choice about some aspects of their care and how they wanted to spend their time. We saw the staff asking people if they wanted to spend time in their own rooms or if they were happy to be within the lounge area. Staff asked people if they wanted to join in with the activities or where they wanted to have their lunch. We also saw that people were able to lock their bedroom doors if they wished to which enabled them to have privacy. However, we observed that people were not asked whether they wanted their main meal at the time it was served. There was no choice given regarding the timing of the meal. One person told us that if they had their breakfast late in the morning, that they were not then hungry at lunchtime.

People told us that the staff were kind and caring. One person said, "I came in for respite for a few weeks but I'm happy so I'm going to stay here, they have very good staff." Another person told us, "Nothing is too much trouble."

During our observations, we saw and heard staff speaking to people in a polite and courteous manner. All staff were seen to be friendly and approachable. They were seen laughing and joking with people and people were relaxed in their company. When staff assisted people with their meal, this was done in an unrushed manner. Staff engaged in conversation and told people what their food was and let them take their time with their eating.

Most of the staff we spoke with knew the people they were caring for well. This included their life history and background. The care records that we saw contained this information which helped staff to have meaningful conversations with people.

There was information within people's care records about their communication needs. Where people were unable to communicate verbally, there was clear guidance in place for staff on how they could assist people to communicate. We saw staff engaging with people who found it difficult to communicate in a kind and caring way. People who had visual impairments had their names written on their doors in braille to assist them with finding their way independently to their rooms.

All three relatives told us that they felt involved in their relative's care. One relative said there was a care plan review due soon and she would very much be part of it. One person told us, "They [the staff] are doing what I want them to do" and went on to confirm that they were regularly asked for their opinion on their care.

Requires improvement

Is the service responsive?

Our findings

We received mixed views from people regarding whether their individual preferences were met such as what time they wanted to get up in the morning or to go to bed at night. One person told us, "They are fairly good at getting me up but sometimes it can be 10:30am. That means breakfast is late though." Another person told us, "The team do the best they can. In the morning I ring my bell. I don't mind what time they come, just when they have time. The night staff often get me up but if not its 9:30am which is pretty good. They know to tell me if they're delayed."

The staff we spoke to told us they felt they could meet people's individual needs and preferences most of the time. We saw that some people were still being got up after 11am but were told by the staff that this had been their preference. We were unable to ask the people as they could not communicate their preferences to us.

People's care needs and preferences had been assessed. There were a number of plans of care in people's care records to guide staff on what care people needed to meet their individual needs. These were in respect of areas such as people's mobility, eating and drinking, continence and mobility needs. However, some people's care records did not contain guidance for staff on how to assist them with their pressure care needs. We told the regional manager about this who agreed to put these in place. We also saw that one person had been recorded as regularly refusing to take their medicines. This had been reported to the GP who had advised the staff to monitor the situation. However, we did not see a clear plan of care in place to advise staff what action to take should this situation arise again.

Most of the staff we spoke with had a good understanding of people's care needs and preferences. However, some of the care records we looked at had not been reviewed and contained some inaccurate information. For example, one person's mobility care plan stated that they were assisted to move with a hoist. However, the staff told us and we observed that they were assisted to move with a stand aid. Therefore staff who were unfamiliar with this person's needs may inadvertently use the hoist which could impact on the person's independence. Another person's care record contained assessments of risks to their safety that had not been reviewed since December 2014 to make sure that the actions being taken to reduce this risk were appropriate. We told the regional manager about this and they agreed that some people's care records needed reviewing which they were currently in the process of completing.

We received mixed views from the people who lived at the service and their relatives, regarding the provision of activities to compliment people's individual hobbies and interests. One person told us, "A man brings music and sings once a month, he was very good I really enjoyed it. The local clergyman came to the home and held a service which was lovely and yesterday we had some seated exercises with balloons and things you shook. It was fun. I've made friends here." Another person told us, "[Staff name] did seated exercises yesterday, which I really enjoyed and there was someone who came with drums and music, I enjoyed listening to him too. I enjoy quiz programmes so I watch TV in my room so I can hear what's being said. I like to read magazines too."

However, a number of people who spent most of their time in their rooms told us that they often felt bored. They told us that the staff did not have any time to spend talking with them. One person told us how the only time they could talk with the staff was when they were helping them with personal care. Another person said, "There's not enough staff to chat, they don't come in. I get a bit bored in here." Therefore some people who chose to spend their time within their room were at risk of social isolation. A relative told us, "People need things to do." Another relative told us, "[Staff name] left, she did activities here. I don't think they have anyone now. They did go into the garden on one hot afternoon. They do very occasionally but they have to have enough staff to do it as so many are in wheelchairs or have mobility issues".

We observed some people taking part in activities during the afternoon of the inspection. This included painting and listening to music. The service had recently employed a member of staff who was responsible for providing people with activities to complement their individual hobbies and interests. They told us that they were in the process of working with people to understand these needs. Their plan was to then provide people with these activities and also see some people regularly who preferred to have one to one chats in their rooms. We saw that this member of staff had drawn up a monthly programme of activities for people. This included gardening, painting, baking, craft

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Is the service responsive?

work, films and singing. The staff member also told us that they were trying to source volunteers who could come into the service and assist people with their hobbies and interests.

People and relatives told us that they felt confident to raise concerns if they were worried about any aspect of the care that was being provided. One person said, "If I had a complaint I would just tell them". However, due to a lack of manager currently being in place at the service, they were unaware of who to raise any concerns with. One person told us, "I wouldn't know who to complain to, there's no manager is there?"

We saw that complaints received were recorded. Four complaints had been received so far this year. We checked one of these complaints and saw that it had been fully investigated and a meeting had been held with the person who had made the complaint to discuss how to resolve it to the person's satisfaction. We were therefore satisfied that people's complaints would be responded to appropriately if they were raised.

Requires improvement

Is the service well-led?

Our findings

There was no registered manager working at the service. The last registered manager had resigned from their post in March 2015. A new manager had started working for the service shortly after this date but they had resigned a month prior to our inspection. The provider was interviewing for a new manager on the day of our inspection.

We found that a number of areas were not being monitored effectively by the provider to make sure that people received good quality and safe care. These areas included the safe management of people's medicines, risks to people's health and safety, the accuracy and security of people's care records, the number of staff required to meet people's individual needs , the completion of staff training and ensuring that the service was working within the principles of the Mental Capacity Act.

The provider's policy stated the manager of the service was to audit a number of different areas each month and that they would monitor this to ensure that these had been completed. However, we found that a number of audits had not taken place within this timeframe which had not been identified by the provider. For example, no audits of medication had taken place between March and July 2015 and the last audit regarding the completion of staff training had taken place in April 2015.

We also found that where audits had identified issues, these had not been rectified in a timely manner. The audit of staff training in April 2015 had found that the staff training matrix had not been completed correctly and that action needed to be taken to make sure that staff had up to date training. The regional manager told us that the monitoring of people's weights should have been sent to the provider's compliance manager each month but this had not happened since April 2015. The provider was only now taking action with regards to these two issues having discovered them since the last manager had left. Other areas of concern that the provider had recently discovered included the lack of protocols in place in relation to 'as and when required' PRN medicines and that some people's care records required reviewing and updating.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The people we spoke with told us that they liked living at the Old Rectory but that their main concern was that there was no manager currently in place and that there had been a number of changes in staff working at the service. All of the relatives we spoke also expressed these concerns. They told us that they felt there was no clear leadership currently in place which therefore led them to feel that the service was not being well led. They told us that they felt the senior staff had 'pulled together' without a manager but were keen to know when a new manager would be in post.

Since the last managers' departure, support and guidance was being given to staff by the regional manager and other managers from the provider's other homes. There was also a deputy manager in place who was away from the service unwell on the day of the inspection. However, staff told us that having a number of different managers had made it difficult for them to always provide good quality care. They said this was because managers wanted things to be done in different way which they found confusing and time consuming. They also said that this had caused a period of instability. However, they were aware that the provider was interviewing for a new manager and felt confident that once one had been appointed, that things would improve.

Staff said they worked well as a team and supported each other. They were able to progress within their roles if they wanted to and complete external qualifications within health and social care. They told us that all of the current managers who were supporting them were approachable and that they could raise any issues they had with them and that they felt confident that their concerns would be actioned upon.

People had been asked for their views on the service and what improvements they thought needed to be made. This was completed through a residents' meeting that took place in June 2015. Some issues had been raised regarding a lack of staff, having different staff at night and providing more snacks such as crisps on the tea trolley. The lack of activities had also been discussed. In response to these comments, the service had increased the number of staff working during the day and night, had tried to have the same members of agency staff working at night and had employed an activities co-ordinator. This demonstrated that people were listened to and that their views on how to improve the quality of the care they received were

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respected. However, we found that a survey that had been conducted for people's views in March 2015 had not been analysed and therefore action in response to people' comments had yet to be taken.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Risks to people's health and safety had not always been assessed or reviewed or actions had not been taken to mitigate these risks. (Regulation 12, 1, 2, a and b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People's medicines were not managed safely. (Regulation 12, 1 and 2, g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were not always sufficient numbers of staff to meet people's needs (Regulation 18, part 1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff had not received appropriate support, training and supervision to enable them to carry out the duties they are employed to perform. (Regulation 18 part 2a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have an effective system in place to monitor, assess and improve the quality and safety of

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Action we have told the provider to take

the service or to mitigate risks relating to their health, safety or welfare. Some people's records contained inaccurate information and they were not always stored securely. (Regulation 17, 1 and 2 a, b and c).