Morecare Limited

Vicarage Court Nursing Home

Inspection report

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23 August 2017
30 August 2017

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	**Inadequate**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 1 August 2017. Breaches of legal requirements were found. We undertook this focused inspection on 23 and 30 August 2017 to check that legal requirements were being met. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Vicarage Court Nursing Home on our website at www.cqc.org.uk"

The service was registered to provide nursing care for up to 39 people. At the time of our focussed inspection 31 people were using the service.

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The focus inspection was carried out to see if the provider had made improvements required to keep people safe. We found no improvements had been made. The overall rating for this service is 'Inadequate' and the service is in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, it will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration if they do not improve. This service has been kept under review and, if needed, urgent enforcement action could be taken.

The inspection was also prompted in part by a notification of an incident following which a service user died. This incident may be subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident.

However, the information shared with CQC about the incident indicated potential concerns about the management of risk. This inspection examined those risks.

Since this inspection a decision has been made that people have moved and will continue to move out of this service.

People using the service were not supported safely. We saw people had not received safe care and treatment as risks to people were not managed in a safe way. People were exposed to risk as they did not

receive the correct wound care they required. People did not always receive their medicines as prescribed; the systems that were in place to monitor medicines within the home were not effective in identifying concerns and placed people at risk. Equipment within the home was not maintained or tested to ensure it was in correct working order which meant people could not receive the support they required. People and relatives raised concerns with staffing levels within the home.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

Risks to people were not managed. The action the provider told us they would take to improve this had not been completed. Medicines were not administered as prescribed. Equipment was not maintained to ensure it was in working order. There were not always enough staff available for people.

Vicarage Court Nursing 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 visit took place on the 23 and 30 August 2017 and was an unannounced focused inspection. We carried it out to see if the provider had taken the actions we told them to take following our comprehensive inspection on the 1 August 2017 where they were rated as inadequate. The inspection visits were carried out by one inspector, an inspection manager and a specialist nurse advisor.

On this occasion we did not ask the provider to send us a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. However we offered the provider the opportunity to share information they felt relevant with us.

We spent time observing care and support in the communal area. We observed how staff interacted with people who used the service. We spoke with four people who used the service and two relatives. We also spoke with three members of care staff, a senior member of care staff and a kitchen assistant. In addition we spoke with two registered nurses, the manager and the provider. We did this to gain people's views about the care and to check that standards of care.

We looked at the care records for eight people. We checked to see if the care they received matched the information in their records. We also looked at records relating to the management of the service, including quality checks and staff files.

Inadequate

Is the service safe?

Our findings

At our last comprehensive inspection the service was rated as inadequate overall and inadequate in 'safe'. We found that risks to people were not managed in a safe way and people did not receive their medicines as required. This was a breach of Regulations 12 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. At this inspection we found the necessary improvements had not been made.

We saw one person had damage to their skin caused by pressure. We looked at records for this person. It was documented this had been acquired at Vicarage Court Nursing Home. The records we looked at stated this person should have two hourly changes of position to relieve the pressure. On arrival we saw this person was seated. Three and a half hours later we saw this person remained in the same position. We advised the manager that this person had not had a change of position since we arrived. They told us they would action this. Fifty five minutes later this person still had not had their position changed. Again we advised the manager of this and told them to take action. This meant this person had not been repositioned in line with recommendations, placing them at risk of developing further pressure damage.

Furthermore, we looked at records for this person from the previous two days. The records were not fully completed and therefore we could not be sure this person had been repositioned two hourly as required. The manager or staff could not confirm to us if this person had received a change of position as required. We looked at records for two other people and found the same concerns.

When people required dressing for their pressure areas we could not be sure this was completed as required. One person had a wound and it was documented that the dressing should be changed every three days. We looked at the records to see whether the dressing had been changed in line with their identified need. There was no documentation available for the previous six days to show if this had been completed. We spoke with the manager and nurses and no one could confirm to us this had been completed. It was also documented that photographs of this should be taken weekly. The last photograph had been taken 12 days before the inspection. This meant we could not be sure the dressing had been changed as required and it was not possible to tell if the wound had increased in size during this time. We found the same concerns for another person with pressure damage.

At our comprehensive inspection we raised concerns with how wound care was managed. At the inspection visit on 23 August 2017 we raised the concerns again with the provider and manager. Following this we requested an action plan telling us what action they would take. At this visit on 30 August 2017we reviewed these actions and found the provider had not taken the action they told us they would. For example, the action plan stated 'Senior staff will be checking all charts and will be reporting any issues to the nurse in charge before the end of every shift, if there are any discrepancies the nurse can resolve this before the end of the shift'. We spoke with a senior staff member during our inspection who was not aware of this action. We then discussed this with the manager who told us that this had been discussed with staff in a meeting in July 2017. The manager confirmed that since our comprehensive inspection, and since the action plan had been completed, there had been no further direction for staff with regards to this.

At the comprehensive inspection we raised concerns that the tissue viability nurse (TVN) had not been contacted to offer support to people with pressure damage. We raised this concern again at the first visit of the focused inspection. By the second visit there was still no evidence that TVN had been contacted.

We looked at records for one person and saw that the administration record for a medicine had been signed on every day. When we reviewed stock we found that the amounts recorded were not accurate. The provider had not identified that there was less medicine than there should be and no action had been taken. Therefore we could not be sure this medicine had been administered as prescribed.

Another person was prescribed medicines with guidance to be administered if their blood pressure was below a certain level. We saw that there was not always blood pressure recording completed before this medicines was administered, therefore we could not be sure this was administered as prescribed.

We saw that when medicines were out of stock no action had been taken to follow this up. For example, one person did not have their medicine in stock for more than four days and so they did not receive this medicine as prescribed.

The action plan we received on 28 August 2017 told us how risks associated with medicines would be mitigated. We saw these actions had not been completed. For example, the action plan said 'the weekly audit will be changed to a daily audit and this will have an action plan attached to it'. We saw that the audit that had been completed did not identify our concerns or have an action plan attached. Furthermore the audit had only been completed on one day.

This is a continuing breach of Regulation 12 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

At this inspection we found concerns with equipment. We saw, and the manager confirmed, that there were no systems or a check in place to ensure equipment was working correctly. We saw documented in one person's file that there were issues about the blood pressure machine and saturation levels machine (SATS) not working when they were unwell. We spoke with the manager about this, who was unaware of these concerns. The manager told us that the previous day they had realised the SATS machine was not working and ordered a new one. This meant for a period of 13 days, this had been broken and would not have been available for people if needed. Furthermore, we looked at nebulisers that people were using and we saw this had not been serviced since 2008. The face mask that was being used was also unclean. We spoke with the manager who was unaware of this. This meant that equipment was not in working order nor suitably maintained for people to use.

This is a breach of Regulation 15 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

At the last inspection we raised concerns about staffing levels. During the first inspection visit on 23 August 2017 we found staffing levels had been reduced by one member of care staff. The provider and manager told us this was because of the reduction in the amount of people who were using the service. One person told us, "There are not enough staff, we had to wait before but now it has impacted much more". A relative said, "There had always been staffing concerns and not enough of them when you press the buzzer". Although we observed that people did not have to wait for support when they requested this, staff had little time to spend with people and no activities were taking place.

At our last comprehensive inspection we raised concerns with the provider's recruitment process and the

action the provider took to protect people from potential abuse. We have not reviewed these areas as part of this inspection as no further staff had been recruited in the last 30 days.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Equipment was not maintained to ensure it was in working order.

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 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not managed. The action the provider told us they would take to improve this had not been completed. Medicines were not administered as prescribed.

The enforcement action we took:

We removed Vicarage Court Nursing Home from the providers registration.