Central England Healthcare (Stoke) Limited

The Old Vicarage Nursing Home

Inspection report

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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

The inspection took place on 22 January 2015 and was unannounced.

The Old Vicarage Nursing Home provides nursing and residential care to older people. The provider had a manager in post who had yet to register with us. 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.

People were protected from avoidable harm because safety risks were identified and managed and the staff understood how to keep people safe.

Medicines were not stored or managed safely.

Summary of findings

There were sufficient numbers of staff to meet people's needs. Staff received training that provided them with the knowledge and skills to meet people's needs, but updates were needed to ensure current guidance was followed.

Infection control systems were not effective in ensuring the service was clean.

Staff sought people's consent before they provided care and support. Some people who used the service were unable to make certain decisions about their care. In these circumstances the legal requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) were followed.

People had access to suitable amounts of food and drink, but their choices were limited because of a lack of information. Specialist diets were catered for.

People's health and wellbeing needs were usually monitored and advice from health and social care professionals was sought when required. Problems with the delivery of care were highlighted.

Staff treated people with kindness and people's dignity and privacy was promoted. People were encouraged to make choices about their care and the staff respected the choices people made.

People and their relatives were involved in the assessment and review of their needs and care was delivered in accordance with their stated preferences.

People's feedback was sought and used to improve the care. People knew how to make a complaint but were not always confident their concerns had been listened to in the past. The provider monitored complaints to ensure they were responded to in accordance with their policy.

The manager and provider regularly assessed and monitored the quality of care to ensure standards were met and maintained. Some areas of concern had not been identified meaning improvements in the quality of the audits were needed.

You can see what action we told the provider to take at the back of the full version of the report.

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.

Staff knew how to raise concerns about poor care or and how to recognise and report abuse. Staffing levels were determined based upon the numbers of people and their dependency. Medicines were not managed or stored safely. Risks to people were assessed. Infection control systems needed to be improved upon.

Requires Improvement

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

Staff were receiving training and updates, but gaps were identified in the clinical knowledge of nurses. The principles of the Mental Capacity Act were being applied to ensure people consented to care and decisions made in their best interests.

Requires Improvement

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

People who used the service told us the staff were caring and approachable, but we observed occasions when people's needs were ignored. People felt they were involved in decisions affecting their care and their privacy and dignity was respected.

Requires Improvement

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

The provider had ensured that people's needs were assessed and plans were in place, but care delivery did not always meet the individual needs of people who used the service.

A complaints procedure was in place. Concerns about how the provider responded to some needs were identified and some relatives did not have confidence that any concerns they raised would be listened to.

Requires Improvement

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

The provider did not have a registered manager in post. Systems were in place for monitoring and auditing the service, but they were not always effective in identifying deficits.

The provider had a development plan for improvements to the service and clear timescales were set out.

Requires Improvement

The Old Vicarage 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 took place on 22 January 2015 and was unannounced.

The inspection team consisted of two inspectors, a specialist advisor for pressure ulcer and Nursing care 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. Our expert had experience of caring for an older person.

We asked the provider to complete 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. We reviewed the information included in the PIR along with information we held about the home. We also spoke with other agencies that had an interest in the home such as the local authority commissioners. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority.

We spoke with eight people who used the service, three relatives, six care staff, the manager and the regional manager. Some of the people living at the home were not able to tell us, in detail, about how they were cared for and supported. Therefore we used the short observational framework for inspection tool (SOFI) to help us to assess if people's needs were appropriately met and they experienced good standards of care. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We viewed five records about people's care and records that showed how the service was managed which included staff training and induction records and audits completed by the manager.

Requires Improvement

Is the service safe?

Our findings

People who used the service were prescribed medicines for occasional use, such as when they were in pain. We saw protocols or guidance for administration in place for some medicines prescribed on an occasional basis but not others. We saw one example where medicine prescribed to help a person manage their mood and anxiety had been administered. There was no clear guidance for staff to follow detailing when the medicine should be given. We saw an entry in the person's daily notes stating the person had been, "Agitated and distressed". Staff we spoke with could not confirm how they recognised 'agitation and distress' for the person or when the medicine should be given. This meant the person was at risk of receiving inappropriate medicines.

Some people who used the service had creams prescribed which they kept in their room and nursing staff told us was applied by care staff. We looked at prescribed creams recorded on medicine administration records (MAR). Nurses were unable to tell us if creams had been applied. We found two examples of prescribed creams in one person's bedroom that were not recorded on the MAR and the date for safe application on the cream had expired. Care staff we spoke with confirmed the creams had been applied. This meant the person had creams applied that were past their expiry date and may not be as effective as they should be.

Medicines stock control systems were ineffective. The amount of medicine was not always carried forward from the previous medication cycle. This meant it was not possible to undertake an accurate audit of the stock of medicines. A person admitted from hospital brought in medicines that were handwritten onto the MAR. There was no record of how much medicine was still in stock for this person on the current sheet. Nurses agreed that the medicines stock for the person would soon run out before the next delivery of medicines. This meant the provider had not managed medicines stock to ensure this person had a constant supply to ensure their wellbeing.

These issues are breaches of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, this equates to Regulation 12 of the Health and Social Act 2008 (Regulated Activities) Regulations 2014.

One person we spoke with told us, "I can wait for ages before someone comes to help me, it can be an hour or more". A relative said, "sometimes there doesn't seem to be enough staff". During one period of observation we noted that a person using the service became very distressed and was shouting out constantly for reassurance. We had to find a member of staff to attend to them and to reassure them. A member of staff told us, "[Person who used the service] doesn't usually sit in this lounge". On other occasions we observed staff were very busy and people told us there were not enough staff. A staff member told us, "We always need more staff, people's dependency is higher than it used to be". A member of care staff told us they were short staffed, they commented, "We are really, you can only do what you can do can't you".

We heard few call buzzers sounding and observed staff responded to people's buzzers in a timely way. The manager told us that staffing levels were based upon the dependency levels of people who used the service. Forty one people were accommodated at the home. We saw the staff rosters confirmed the number of staff usually provided and where deficits had been identified the manager made arrangements for supplementary staffing to be provided.

Staff told us and we saw that recruitment checks were in place to ensure staff were suitable to work at the service. Information included requesting and checking references of the staffs' characters and their suitability to work with the people who used the service.

The management of infection control and hygiene standards were not effective or safe. Regular cleaning schedules were in place, but these were not effective in ensuring all areas of the home were clean. A relative involved in daily care expressed some concern about infection control in the home and gave us an example saying, "Crockery and other items are not washed thoroughly". We observed that some crockery was washed or rinsed in the kitchenettes rather than being washed in a dishwasher. We spoke with the provider and raised these concerns. They immediately requested that the concerns were addressed, but on checking we found 'dirty' beakers that we had been told had been washed.

Medicine for people recently admitted was in open plastic boxes on the working surface of the treatment room. There were boxes of dressings without lids. These items were not

Requires Improvement

Is the service safe?

in cupboards or locked away. We observed that some surfaces in the medicines room were not clean. The extensive storage described did not allow cleaning of the room and may present a cross-infection risk.

A relative told us, "I think people are safe" and one person commented, "Yes I feel safe". Staff we spoke with told us they felt the service offered safe support. They confirmed they had received training in the recognition and reporting of suspected abuse. This was confirmed from the training records we looked at. One staff member told us, "If I saw anything that I wasn't happy about I would report it immediately". Staff were able to provide examples of what constituted abuse and told us they would always report it. They confirmed the provider had policies on how to report abuse to the relevant agencies. The manager told us they had undertaken an audit of recent safeguarding concerns, to try to establish if there were themes and if the improvements could be made.

Risks were recorded and assessed but relatives raised concerns about people's care. A relative told us, "There have been occasions when my relative hasn't been able to get out of bed because the hoist hasn't been charged. This is not good enough". We spoke with staff about this, we were told, "We haven't been able to get everyone up yet today because one hoist is broken and the other hoist is being used in the old end of the home". We noted in records that a hoist had been placed out of action because of an electrical fault. This meant there was insufficient operational hoists available to meet people's needs.

Risk assessments were in place for the evacuation of people in the event of an emergency. These were personalised to each individuals needs and described the support they would need. Fire safety risk assessment of the building had been agreed with fire safety officers. This showed the provider had assessed and planned for the risk of emergency.

We recommend staffing levels are continually reviewed to ensure sufficient staff are available to meet the needs of people who use the service.

We recommend a review of infection control systems to ensure the provider meets the criterion of the Health and Social Care Act 2008, code of practice on the prevention and control of infections and related guidance.

Requires Improvement

Is the service effective?

Our findings

A relative told us that they always checked to ensure their relatives care needs were met as they should be. They identified having to remind staff to undertake care tasks that hadn't been carried out. For example they said, "I have to remind staff to place a pillow to stop [person using the service] skin breaking down. I have done that more than once". The relative showed us how they ensured the person who used the service's skin was protected. We noted that for most people, assessments had taken place to assess risks of pressure ulcers and pressure relieving equipment was provided where people were at risk. However, we found one person had a pressure ulcer, there was no wound management plan in place and no subsequent information recorded. In another example we found that pressure ulcer care instructed by a healthcare professional had not been carried out. This meant the provider had not managed these people's care and health needs.

People we spoke with could not always tell us if their care needs were being met, because their ability to recall was impaired. There were eight people with diabetic needs, four of whom were prescribed insulin. A recently admitted person had diabetes recorded in their medical conditions but there was no care plan or reference to this since admission. There was no evidence that the person's diabetes had been monitored. The nursing staff we spoke with confirmed this to be the case and told us they did not have up to date training in diabetes management and care. This meant the person had been placed at risk because of a lack of knowledge, assessments and care delivery.

These issues were a breach of Regulation 9, of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010 this equates to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they thought staff had received the training they needed. Relatives gave mixed accounts of staff's abilities. One relative said, "They do receive training but they don't always do what they are supposed to". A staff member told us, "We do receive training and updates. I'm going to ask for medicines training". Another staff member said, "We've all received manual handling training and assessments". We saw records of staff training that confirmed staff had received essential training to meet people's needs and observed staff supporting people to mobilise appropriately.

We received mixed messages about the food provided. One person told us, "They've no variety, we've had chicken three days one after the other". "Some days it's just toast as they say they've got no beans or anything". A relative said, "Meals are alright". Kitchen staff told us what the meal choices of the day were but none of the care staff we spoke with could tell us. This meant they were not able to tell people who used the service what food they were eating and there were no menus on display or available when we asked. This showed that people had limited information and choices about the food they received.

During lunchtime on the first floor the meals were delivered pre plated via a 'dumb waiter'. We observed all the meals were put uncovered on a table so that staff could take each plate to each person. We spoke with the operational manager about this, they told us they had asked for the meal time procedures to change so that food was presented covered by a cover, then served straight from the dumb waiter to each person. They believed these changes had been implemented and agreed to reiterate and instruct staff further.

We observed the meal time experiences of people who used the service. We noted that when people required support they were usually afforded that support by the staff team.

We saw that daily intakes of food and drink were well recorded. A relative told us they visited at least three times per day and ensured the [person using the service] had drinks.

Some people who used the service did not have capacity to make certain decisions. The Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) set out these requirements that ensure where appropriate, decisions are made in people's best interests when they are unable to do this for themselves. The staff demonstrated they understood the principles of the Act and they gave examples of how they worked with people to make decisions in their best interests as required. Care records confirmed that mental capacity assessments were completed and reviewed, and best interest decisions had been made in accordance with the legal requirements. We were told that there was one DoLS authorisation in place. There was a copy of the authorisation with the care records for this person. The provider had ensured the agreed restriction to keep the person safe from falling was being implemented in their best interest.

Requires Improvement

Is the service effective?

We saw that Do Not Attempt Cardio Pulmonary Resuscitation orders (DNACPR's) for some people were in place. We spoke with one relative who confirmed they had had an opportunity to discuss their relative's wishes. We saw that best interests assessments had been carried out where people lacked capacity to make an informed decision with regards to the DNACPR's, which ensured any decisions made were in the person's best interest. All the DNACPR's we looked at had been reviewed on a regular basis by the G.P and with the consent of the relative, to ensure the persons wishes remained the same.

Requires Improvement

Is the service caring?

Our findings

We observed that staff approached people in a kind, caring way and they responded positively smiling and cheerfully chatting to the staff. One relative told us that staff were approachable and friendly and they could discuss aspects of their relatives care with them. This was a necessary and very important for them. We also observed one person who was living with dementia shouting out constantly and in distress. Staff did not attend to the person and we had to seek out assistance for them. Staff told us, "[Person who used the service] is not usually in here" and "This is what they do, their partner will be here this afternoon and they will settle then".

Staff confirmed one person was receiving end of life care. We saw that most medication had been withdrawn. The person was unable to take food/fluids but there was no end of life care plan in place for this person although changes had occurred and the person's needs were changing daily. There had been no input from specialist palliative care professionals. This meant the provider had not responded to ensure suitable arrangements were in place to ensure the person received appropriate end of life care.

We also observed positive interactions. We saw one staff member carefully supporting a person to drink by giving them sips of tea from a beaker and saying to them, "It doesn't matter, doesn't matter if it spills" and "have some more for me". The staff member gently persevered until the person had finished the drink. We observed other staff actively engaging people in activities and conversation.

A proportion of people had high dependency needs. Some were cared for in bed and many spent time in their bedrooms. We saw staff monitoring people in their bedrooms as staff moved around the home. We observed people responding positively to the interaction with staff at these times.

Information was available to people who used the service and visitors about Dignity in Care and the staff who were nominated as dignity champions. We saw examples of staff ensuring people's privacy and dignity. Bedroom doors were closed when personal care was given. Visitors were asked politely to give them time to support people ensuring their privacy and dignity. A relative told us, "Oh yes, they always knock before they come into the bedroom".

We saw the provider produced a newsletter periodically the last one was for Autumn 2014. The newsletter provided people and visitor to the home with information about new staff and those that had or were leaving, staff training sessions and plans for future training. Details of our last inspection was included, social events that had taken place and any development plans for the future. In addition relatives meetings were arranged.

People were afforded choices, although a relative commented, "My relative doesn't always have a choice; they put her to bed in the afternoon every day even though she likes to watch the television". We discussed these concerns with the manager for their review. We observed that some people needed to have 'bed rest' to relieve pressure and to ensure their skin remained healthy.

A member of staff told us, "There are residents here from when I first started here, they are like an extended family really. When the weather is good we do a bit of gardening and they love that. If they don't want to do something (activity) that's arranged we just do what they want, there's no point in doing it if they don't want to". This showed that people's preferences were respected.

Relatives we spoke with told us they could visit at any time. One relative said, "I'm here every day" another said, "There are no restrictions that I'm aware of". This meant people could have visitors at the time they chose.

Requires Improvement

Is the service responsive?

Our findings

People's individual needs had been assessed prior to and during admission to the service. A relative confirmed they had been included and involved in the assessment process, they told us, "Yes we were able to talk about what [person who used the service] wanted and did".

Each person had a plan of care that had been developed from the initial assessments and any reviews that had taken place. Care plans contained detailed information about people's health, social and personal care needs and had been reviewed. Four relatives told us they were involved in their relatives care and felt able to discuss important issues with nursing or care staff.

A relative told us that their relative should have a bath weekly, but staff had to be reminded about this and three weeks had passed without a bath. They told us they had insisted their relative receive a bath. The records we looked at showed that the person had not been bathed as frequently as they should have. This meant the provider had not responded to this person's personal hygiene needs.

A relative told and showed us how staff had not provided pressure relieving equipment as they should to relieve friction and the risk of skin breakdown. They told us, "I always have to check, they often don't do it right".

We noted that some people were described as presenting with challenging behaviour or were 'resistant' to care. One person was described as aggressive to staff. We were told that referrals to relevant health professionals had been made and a chart put in place to record incidents of the behaviours described. The manager said, "Their needs have changed and we don't think we can any longer meet them in this environment". A second person did not have clear plan of care for the management of their difficult behaviour for staff to follow. Staff had received training in the care of people who were living with dementia, but additional training and guidance regarding the management of a person's challenging behaviour would ensure people would receive appropriate therapeutic support.

We observed that some people were encouraged to take part in a number of activities during the morning period. The activity coordinator showed enthusiasm for their role but was not able to generate a lot of interest. They told us, "I try to provide some group activities and then one on one. It can be harder during the colder weather to get people to be involved". We noted that people's individual interests had been recorded in their care records.

People we spoke with and relatives told us they know how to make a complaint or raise concerns if they needed to. We received a mixed response when we asked if concerns were responded to appropriately by the provider. One relative said, "We've raised concerns in the past, and didn't feel we had been listened to". Another said, "I always tell staff about my concerns, sometimes that is enough to sort it out and others it isn't. I visit all the time to ensure my relative has the care they need". One relative raised concerns about toileting, hoisting and pastoral care, citing long waits for assistance to take their relative to the toilet resulting in 'accidents'. They told us that hoist breakdowns had meant their relative spent large amounts of time in bed and gave examples when pastoral care was arranged for the home, but their relative had not been included. These concerns were raised with the manager and regional manager to address. They discussed the concerns and agreed to address them.

Requires Improvement

Is the service well-led?

Our findings

The provider had recruited a manager, who had yet to be registered with us. The new manager was clear about their role and responsibilities as a manager. People and their relatives commented on the changes to the management of the service. One person told us, “There have been three managers recently, it’s unsettling”. Another said, “There have been three managers, one after the other” and “The one in the office has been here for two months now. We haven’t got to know her yet”. Another relative said, “I have spoken to her a couple of times”. A staff member said, “I’m hoping the new manager will take control, some staff do their own thing. There is a need for strong leadership”. Another staff said, “I’m glad we have a manager now, we need it”. We saw that a meeting was arranged for relatives and people who used the service to inform them of the changes to management and developments for the future.

A care staff we spoke with said, “Appraisals and supervision have been a bit hit and miss, but the new manager has a plan in place and she listens. Things have started to improve”. The manager showed us the plans they had to arrange regular one to one meetings with staff to discuss their performance and development or training needs. Staff meetings were being organised. A staff member confirmed this.

The manager and the regional manager told us, they had carried out audits of all aspects of the service, and had identified areas for improvement and development. We were told, “The provider insists on auditing so they know what needs to be done we have an action plan in place that clearly identifies what we need to do and when”. We identified that some audits had not effectively identified concern about the service delivery for example, medicines management, infection control and the first aid box content did not match the list of contents on the record despite recorded as checked. We also found the arrangement for the disposal of medicines was not effective, with large amounts of medicines for disposal stored in the home.

The provider had been awarded Investors in People award and showed us a business plan developed from recent audits and monitoring of the service. There was a clear guide for the manager to work on with timescales for completion. This meant where there was a need for improvement, changes for the benefit of people were had been identified and would be completed within agreed time frames.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: People who use services were not protected against the risks associated with unsafe use and management of medicines. Reg 12(2)(g). People who use services were not protected against the risks of inappropriate care. Reg 12(1).