Clarkson House Residential Care Home Ltd

The Vicarage Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

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

The Vicarage is a large Victorian property that has been extended and adapted into a care home for older people. Bedrooms are located on the ground and first floor and storage and the laundry are located in the basement. There is one lounge and two dining rooms. The Vicarage is registered to provide accommodation for up to 30 older people and is situated in the Audenshaw area of Tameside.

At the time of our inspection there were 28 people living at the Vicarage.

This inspection was carried out over two days between 21and 22 May 2018. Our initial visit on 21 May was unannounced.

We last inspected The Vicarage in January 2017. At that inspection we rated the service as good in the caring domain and requires improvement in safe, effective, responsive and well-led. The overall rating for the service was requires improvement. At that inspection we found regulatory breaches of three Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These previous breaches related to the safe management of medicines, the safe management of premises and equipment, staff training and induction, and ineffective governance of the service. Following the last inspection we asked the provider to complete an action plan to show what they would do and by when to improve the key questions to at least good.

The service had a registered manager in place. 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.

At this inspection we identified repeated breaches of three regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also identified breaches of three further regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The total of six breaches related to a lack of person-centred care, poor infection control, keeping people safe, staff numbers, medicines, dignity and respect, safety of the building and equipment, incorrect diets, complaints, staff training and induction and inadequate governance of the home. You can see what action we told the provider to take at the back of the full version of the report.

We identified three breaches of the Care Quality Commission (Registration) Regulations 2009. These were a failure to notify us of death of service users and other incidents at the home and a failure to display previous inspection ratings.

We made one recommendation to ensure the home's décor is more dementia friendly.

The home did not provide person-centred care and people were not involved in planning their care. People did not have keys to their rooms and a 'bathing schedule' was in place. Activities were only provided twice per week and people were not offered any personalised activities.

We found poor cleanliness and infection control practices throughout the inspection. The home was malodorous and the laundry system used at the home posed a potential risk to people through cross contamination.

Accidents and incidents were recorded; however, no action had been taken to analyse trends or mitigate further risk to people.

Up-to-date risk assessments were not always in place for people or the building.

Medicines were not always stored or managed safely. Staff had not had their competencies checked to ensure medicines were administered safely.
People were not always treated with dignity and respect.

Staff did not always use safe moving and handling techniques when assisting people.

People's movement around the home and grounds was restricted. The registered manager, or other staff members, did not know if people living at The Vicarage had Deprivation of Liberty Safeguards (DoLS) in place. No capacity assessments were carried out.

Systems and processes to safeguard people were not in place and the registered manager did not demonstrate they had sufficient oversight of safeguarding at the home. Not all staff had undergone training on how to safeguard people from abuse.

People who had been prescribed a specific diet were not always receiving their food prepared to their requirements. This placed people at the risk of harm.

The building required a full health and safety audit. Fixtures were in poor condition and wardrobes were so unsafe we requested they be fixed to the walls immediately.

Some of the required safety checks and maintenance for the building and equipment were in place and regularly monitored. However, there was no testing of the safety of water systems. Legionella testing was not in place. There was no hot water feed to many rooms in the home and the registered manager had installed individual water geysers. There was no risk assessment in place to demonstrate the safety of these geysers.

Actions from the previous fire risk assessment had not been completed from November 2016. We requested the local fire service conduct a visit to the home to ensure safety of the people living at the home. This resulted in action being taken by the fire service.

There was a complaints book in place; however, people were not made aware of their right to make a complaint about the service. There was no complaints information displayed in communal areas and people did not receive a welcome pack or handbook on arrival at the home.

There was no training matrix in place in order for the registered manager to keep oversight of staff training. We received information regarding staff training 20 days after we requested it and found there were gaps in the training that staff are required have.

The registered manager told us they rarely held staff meetings or provided supervision for staff. There was no staff appraisal system and no competency checks were carried out on staff to check their performance.

There was no coherent dependency tool used by the registered manager to ascertain safe staffing levels and the rotas we reviewed did not reflect safe staffing levels. Staff and visitors told us they felt staffing levels were too low at the home and we observed several instances at the home where staff were not present for periods of time.

Governance of the home was inadequate. The registered manager did not employ systems and processes to keep an operational or strategic oversight of the home. The registered manager is present at the home part-time and does not have a management support structure in place.

The registered manager had not completed statutory notifications to CQC of any accidents, DoLS, serious incidents, and safeguarding allegations as they are required to do. This had been identified as a failing during the last inspection; however, the registered manager had continued to be non-compliant in their requirements to submit notifications to CQC.

The staff files we looked at showed us that safe and appropriate recruitment and selection practices had been completed by management to satisfy themselves that suitable staff were employed to care for vulnerable people.

We received mixed feedback from residents and visitors about the quality of the food at the home. There was a menu in place with a set meal each day. There was no alternative listed on the menu; however, the cook told us they would make something different if the person wished.

Care records at the home showed us that people received input from other health care professionals, such as district nurses and opticians.

People, their relatives, visiting professionals and staff gave us mixed comments around the care and support they received at The Vicarage. Some people told us they were happy with the care provided at the home and some people felt there needed to be improvements.

We observed some good, caring interactions between staff and people who lived at the home; however, we also witnessed incidents where people were not treated with dignity and respect which required us to report our concerns to the registered manager during the inspection.

The overall rating for this service is 'Inadequate' and the service is therefore 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, 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 within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Cleanliness and infection control practice was poor.

We identified concerns regarding the safety of the building and equipment.

Medicines were not always stored or managed safely.

People were not always assisted by staff using safe moving and handling techniques.

There were inadequate systems and processes in place to safeguard people from the risk of harm.

Accidents and incidents were not analysed and action had not been taken to mitigate any future risks to people.

Is the service effective?

Inadequate

The service was not effective.

People did not always receive their meals as prescribed by the speech and language therapy service.

People's movement was being restricted around the home. The registered manager and staff were not aware who required a DoLS and who had one in place.

There were no capacity assessments carried out and staff we spoke with were not aware of the Mental Capacity Act 2005.

Not all staff had the necessary training in place. The registered manager had not ensured staff were adequately trained to effectively care and support the people living at the home.

Is the service caring?

Inadequate

The service was not caring.

We saw some instances where staff were kind and caring whilst delivering support; however, we also observed incidents where people were not treated with dignity and respect.

People did not have information in care records around their communication needs or their likes and dislikes.

People were not always spoken with or explanations given whilst staff were delivering care.

Is the service responsive?

Inadequate

The service was not responsive.

People did not receive person-centred care. People and their relatives were not actively engaged in the planning or reviewing of their care.

Staff told us they did not read care plans.

Activities were few and people were not supported to follow their personal interests.

People were not given information on how to complain about the service and the care they received.

Is the service well-led?

Inadequate

The service was not well-led.

Statutory notifications had not been submitted to CQC as required since 2016.

Some low-level audit systems were in place to monitor the quality and safety of the service; however these were disorganised, incomplete and had not identified the issues we found during the inspection and were therefore ineffective.

Necessary policies and procedures were not in place to ensure people received safe care and treatment.

The registered manger did not demonstrate oversight of the running of the home and knowledge of their responsibilities around safeguarding people from the risk of harm.

The Vicarage Residential 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 21 and 22 May 2018 and day one was unannounced. The inspection was carried out by two adult social care inspectors and one hospitals inspector on day one. Day two was carried out by one adult social care inspectors and one hospitals inspector.

Before we visited the home, we checked information we held about the service including information requested from Healthwatch Tameside, the local authority and statutory notifications received at CQC. We did not have information from these sources to enable us to include in our planning. Statutory notifications are information the provider is legally required to send us about significant events that happen within the service.

On this occasion, we had not asked the service to complete a Provider Information Return (PIR). This is a document that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the two days of inspection, we reviewed a variety of documents, policies and procedures relating to the delivery of care and the administration and management of the home and staff. This included six people's individual care records, a sample of seven people's administration of medication records and five staff personnel files to check for information to demonstrate safe recruitment practices. We also attended the morning staff handover meeting on the first day of our inspection.

As some people living at The Vicarage were not able to tell us about their experiences, we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us.

We walked around the home and looked in all communal areas, bathrooms, the kitchen area, store rooms, smoking room, the medication room and the laundry room. We also looked in several people's bedrooms.

As part of the inspection process we observed how staff interacted and supported people at mealtimes and throughout the two days of our visit in various areas of the home. We spoke with five people who use the service and four relatives. We also spoke with the registered manager, the team leader, the cook, five care staff members and one visiting professional.

Inadequate

Is the service safe?

Our findings

We looked at staffing numbers at the Vicarage to ascertain if safe and appropriate levels of staff were on duty during the day and night. During the inspection we observed several instances where people were left unattended in the lounge area. Some visitors and staff told us they felt there were not enough staff. At the start of the inspection the registered manager told us they did not use a dependency tool to assess safe staffing levels; however, the team leader later produced a dependency calculator. - We were not able to understand the relevance of the calculator and the team leader was not able to explain it to us. However, the registered manager told us a minimum of four care staff plus a team leader needed to be on shift each day. During a review of previous staff rotas, we found these staffing levels were not always in place during the day shift and we saw several instances where three care staff were on duty in place of the required four.

Staffing levels for the night shift meant there were two care staff on duty to support 28 people over two floors and 24 of these people were living with dementia and others who may require the assistance of one or two staff for their personal care needs. We were also made aware that night staff have a task sheet to complete whilst on shift. These tasks include laundry duties each night. The laundry was situated in the basement and therefore, one staff member would be left alone for a period of time to cover both floors of the home. This placed people and staff at risk if more than one person required assistance, if a person required the assistance of two people or there was an emergency.

The fire risk assessment from November 2016 stated current night staffing numbers were not sufficient in the event of an emergency and stated a minimum of three night staff are required to ensure the safety of people. This concern was also highlighted and documented in the previous inspection report published January 2017. We again spoke with the registered manager around safe night staffing numbers and they told us that they had not implemented this as they felt it was not up to a fire risk company to tell them how many staff they should have working on night shift.

The above examples demonstrate a breach of Regulation 18.1 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Checks for the safety of premises and equipment had mostly been carried out and were up-to-date. For example, these included gas safety checks, lift maintenance, fire extinguishers, PAT testing and electrical installation. Equipment, such as hoists and slings were also checked within guidelines. However, we found that no water safety checks had been carried out at the home. The registered manager told us there were thermostatic controls on direct feed hot water system but not all rooms had direct water feed and were fitted with individual water geysers. These geysers were old and the temperature controls had been taped with gaffer tape to a set temperature. We did not see evidence of any risk assessments or regular safety checks for these geysers in the safety checks information provided to us. We spoke with the registered manager around an accident and incident record we had identified where a staff member had been scalded using a water geyser in someone's bedroom. The registered manager told us this had now been fixed and could not supply us with an explanation of how this had happened. No testing or risk assessments were

carried out for Legionella safety of the water systems. The registered manager has a legal duty to carry out an assessment to identify and assess whether there is a risk posed by exposure to legionella; however, they told us they did not need to do this testing. The registered manager was not able to provide us with evidence that they did not need to do this. We requested this testing was carried out as soon as possible.

We reviewed the fire risk assessment from November 2016 and found this should have been reviewed in November 2017 and this had not been completed. The assessment gave a list of high risk action points that had been highlighted in the previous inspection. We requested evidence that all risks had now been actioned; however, the registered manager was not able to provide us with evidence for all actions. Therefore, we contacted the local fire service and asked them to visit the premises to check that fire safety systems were in place and satisfactory. As a result of our referral, the fire service identified four breaches of The Regulatory Reform (Fire Safety) Order 2005 and issued a notification of deficiencies.

We found that people had personal emergency evacuation plans (PEEPs) in place in care plans. A PEEP provides additional information on accessibility and means of escape for people with limited mobility or understanding. This includes a plan specifically designed for an individual who may not be able to reach a place of safety unaided in an emergency situation, such as a building fire. These PEEPs identified how many staff were required to provide assistance. However, we found stated in the fire risk assessment that the home did not have a suitable emergency evacuation procedure in place. This meant that although PEEPs had been written, the overall building did not have a safe evacuation procedure and PEEPs were not stored in a central area for the fire service to obtain immediately.

During our tour of the home we checked to see that areas were clean and if good infection control practices were employed. We identified a number of concerns around infection control practice. There was no safe laundry system in place. Individual laundry bags that could be closed were not used to separate soiled items. All items for the laundry were bundled together in broken, open-topped plastic baskets. Dissolvable sluice bags were not used to separate contaminated items from general wear items and all were placed together in washing machines. The basement laundry area was not clean and there were no hand washing facilities or access to personal protective equipment (PPE). Clean bedding was stored against bare, dusty walls. There was a mop sink in the basement which was extremely soiled.

We found The Vicarage was unclean and malodorous. The registered manager employed a cleaner to work three hours per day; however, this was insufficient for a large, 2-storey building with 28 bedrooms and a basement. We found the vinyl chairs used by people for sitting in the lounge were dirty, sticky and we found unidentified tablets stuck to the side of one chair. We requested all the chairs were checked and cleaned during our inspection. On several occasions we found there was no hand washing soap in dispensers and requested they were filled. Baths were not clean and we found a number of items in bathrooms that may cause harm to people. Items we found included soiled shoes, a razor blade, disinfectant and a soiled continence product. We asked the registered manager to arrange to have these items removed as soon as possible. We found the sluice machine was not in a separate locked room, but was situated in the corner of a toilet used by residents on the first floor. Slings are prescribed specifically for named individuals and should only be used by these people for medical and infection control purposes. However, we found slings hung up together and staff confirmed they were used by more than one person.

Visitors we spoke with gave us mixed answers when we spoke with them around cleanliness of the home. One visitor told us, "I don't like the carpets as they smell. The chairs need cleaning." Another person told us, "I think it's very clean."

We visited one person's bedroom and found they had a thin crash mat at the side of their bed that was

soiled with faeces. We also saw that the wall at the side of their bed was soiled with faeces. We requested this room be cleaned as soon as possible. Staff told us that when changing bedding they had been told to only change the bottom sheet of a soiled bed and to leave the quilt cover on to minimise the amount of laundry.

There was no infection control policy in place and we directed the registered manager to the Health and Social Care Act 2008 Code of Practice on how to implement a safe laundry system. However, we checked with the registered manager that this had been implemented three weeks later and found progress had not been made.

We found The Vicarage was not conducting their service in line with the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections Guidance.

As part of our inspection we looked at how accidents and incidents are recorded, analysed and acted upon to minimise the risk of future accidents and incidents occurring. We found an accident recording system was in place and included a yearly and monthly tracker. Some accident forms were completed fully and some had important information missing such as the time of the accident. Additionally, follow up information was not recorded, i.e. what injuries the person sustained and diagnosis if they had been transported to hospital. For example, it was recorded someone had fallen and was complaining of pain and an ambulance was called. We asked staff what injuries the person had sustained and we were told they had sustained a fractured hip; however this was not recorded. We found that although some accident information was recorded; no analysis was carried out and actions taken to mitigate any further risks to people and prevent further accidents.

We had identified during our review of accidents and incidents that a number of people had suffered a head injury and we requested a copy of the home's policy and procedure on head injuries. There was no policy in place and no effective procedure. Staff told us they complete a basic observation chart; however, the observation chart did not contain any information around signs a person required medical assistance to guide staff. We also requested information around how people's high risk medicines were managed; however, there was no system in place to ensure the safe management of these medicines. We raised our concerns with the registered manager regarding the lack of these two systems as there were 17 people living at the home who were prescribed anticoagulant medication. People who take anticoagulant medicines are at a higher risk of internal or profuse bleeding when they have suffered an accident and plans should be in place to manage this risk.

When incidents occur where people had suffered an injury, the registered manager is required under the terms of their registration with CQC to inform us of these incidents. However, we had not received notifications since 2016 despite a number of injuries occurring at the home in this period.

We looked at the way in which medicines were managed at The Vicarage to check that people received their medicines in the right way at the right time. The home used a local community pharmacy to manage the stocks and deliver the medicines.

During our inspection we found that some medicines were kept in a medicine trolley and securely stored in the medication room when not in use. However, we also found some medicines were stored in locked cupboards in people's bedrooms. Temperatures of these areas were not checked and recorded daily for safe storage. Medicines should be stored in areas with temperatures below 25 degrees and be monitored daily as high temperatures can compromise the quality of the medicines. We found the temperature to be hot in one person's bedroom and we requested a thermometer which quickly rose to 25 degrees in the

room. This meant medicines were not being stored within safe temperatures. We also checked that medicine fridge temperatures were monitored and maintained and we found safe temperatures were not maintained and daily records were not comprehensively kept. This had been identified by the pharmacy supplier when they had carried out their own audit of the medication system at the home in July 2017. This was also highlighted as an area for improvement during our last inspection. Digital thermometers should be used to accurately record the storage temperature of medicines and these were not used.

We reviewed the medicines administration records (MARs) of seven people and conducted a check to consolidate tablet numbers. We found tablet numbers balanced and MARs had been completed. However, we found a number of items, such as dressings to be out of date. Information in the individual medication records was insufficient as not all included information on allergies or included photographs to enable staff to identify the right person was receiving the right medicine.

Several staff had received training on medication administration; however, they told us the team leaders were the only staff to carry out the medication rounds. We found there was no system in place to check the competencies of staff regarding medication administration and these had never been carried out. We requested copies of any full medication audits and we were given a MARs sheet audit dated May 2017; this contained a list of errors that had been identified on the MARs. However, there was nothing recorded as action taken as a result of these identified errors.

Suitable arrangements were in not in place to help safeguard people from potential abuse. Not all staff had received up to date safeguarding adults training. When we spoke with staff around their knowledge of safeguarding and found they had limited knowledge. They were able to give some information around safeguarding; they told us they would tell the team leader or registered manager if they suspected anyone was at risk of abuse.
We also identified that not all people had a call bell in their bedroom or the call bell cord did not reach past the middle of the bed to enable people to request assistance from their bed. This meant people may not be able to request assistance when required. There were no risk assessments in place for people who, due to their disability, may not be able to use a call bell.

The home had a hairdresser visit once per week. However, there were no facilities in place to accommodate the hairdresser and staff told us they used the smoking room to cut and style people's hair. There was no risk assessment in place for the smoking room.

Risk assessments were in place in the care plans we reviewed. Examples of these risk assessments were for falls, isolation, skin integrity and the use of the hoist. During our review of these assessments we noted one person's records stated they mobilised around the home unaided. However, we observed this person was being moved around the home in a wheelchair. We checked with staff and found the person had recently deteriorated and was now using a wheelchair; therefore, written records did not reflect the care needs of the person. We highlighted this and spoke with the registered manager around the need for records to be accurate and up-to-date.

Throughout the inspection we observed examples of staff assisting people to move around the home and from wheelchairs to armchairs. We noted some good practice during moving and handling; however, we also observed several instances where poor practice was used and people were put at the risk of harm. We observed people were assisted to rise from chairs where staff used unsafe under-arm lifting techniques. We also saw one person who was assisted to stand using a handling belt that was incorrectly positioned under their arms and the person was not weight-bearing. This person was distressed as result of this incident and we had to report the situation to the team leader who intervened. We requested the person was checked

over for any injuries and to be provided with reassurance. We also reported the other instances of unsafe moving and handling incidents to the registered manager.

The above examples regarding medication, infection control, fire safety, accident management and people's safety demonstrate a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

During the inspection we looked at five staff personnel files to check that safe recruitment practices had been undertaken. We reviewed these files to check they contained required information including, a full work history, photographic identification checks, health information, a minimum of two references from previous employers and checks from the Disclosure and Barring Service (DBS). The DBS carries out checks and identifies to the home manager if any information is found that could mean a person may be unsuitable to work with vulnerable adults. We found that the personnel files contained all the required information. This meant that robust and safe recruitment practices had been followed to ensure that suitable staff had been employed to care for vulnerable people.

Inadequate

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw that less than half of staff had undergone this training on DoLS and no staff had any training on MCA. Staff we spoke with during the inspection demonstrated they had no knowledge around MCA and DoLS and were unable to tell us what this meant for people living at the home.

We found people were restricted in their movements around the home. Staff and relatives told us people did not have access to the garden and no-one was using the garden during our inspection. Staff told us there was not enough staff to supervise people in the garden and the lounge. We identified that both dining rooms had overhead latch locks on the outside of each door. Staff told us the dining rooms were locked after mealtimes so people could not access them unaccompanied. During the initial tour of the home we found in people's bedrooms they had sensor alarms across their beds that instigated an alarm if the sensor beam was broken. The team leader told us they were in place to alert staff to someone falling or getting out of bed. However, they told us everyone living at the home had these sensor beams in place and no individual assessments had been carried out as to whether the person needed this safety measure or not.

The registered manager or team leader was unable to tell us who living at the home had a DoLS in place. There was no system in place to track or review existing DoLS. The registered manager told us they relied on the local authority to send them an email when a DoLS was due for renewal. No capacity assessments were carried out at the home and no systems were in place to identify who required an assessment for DoLS. Subsequent to the inspection we found there were eight out of 28 people living at the home with a DoLS in place. A lack of assessments in place meant that people may require the legal safeguards to be in place but have not been identified for assessment. A lack of knowledge, oversight and monitoring of DoLS meant there is a risk people may not have up to date authorisations in place.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

During the inspection we looked at food choices available. There was a three-week rolling menu in place

with one meal listed and no options on the menu; however, the cook told us they would make an alternative if the person wished. The cook told us they asked people each day if they were happy with what was on the menu for the next day and if not, they would ask them what they wanted instead. The cook told us they asked people what they liked to eat when deciding what was on the menu.

We observed the lunch mealtime experience for people living at the home. Tables were set with plastic tablecloths and plastic flower arrangements. People had paper napkins; however, there were no condiments. We did not see that people had been offered coloured plates; adapted cutlery or pictorial menus to assist them to choose their meals or eat independently. People were served blackcurrant cordial and later offered a choice of tea or coffee. We observed one staff member showing the jug of juice to a person to help them decide if they would like some. We saw that people who required assistance to eat were not given full attention by staff who were assisting them. We saw one lady was being assisted by a staff member who left her mid meal to take someone to the toilet. Another person was assisted by three different staff members to eat one meal. We observed some caring and attentive interactions between staff and people. Some staff made conversation during the meal and asked people if they were alright. However, we also observed that staff were rushed and people had to wait for their food to be served prompting comments from people. We heard staff tell people to "sit down" or "eat your dinner" on several occasions. We witnessed one incident where a staff member took a cup of tea from a lady and spoke to her in an undignified manner. We reported this incident to the registered manager.

People we spoke with gave us mixed opinions on the food served at The Vicarage. One person told us, "The food is alright." Another person told us their thoughts about the food, "Sometimes it's nice. Sometimes it's not."

People with certain health conditions require their food to be prepared in a specific way to ensure they can eat their food comfortably and safely. For example, some people need their food mashed or pureed due to swallowing difficulties. In addition, people who had been prescribed a fortified diet need to have their food enriched with high calorie additions, such as cream, at each meal time. We spoke with the cook and looked at information kept in the kitchen area to inform them of these specific dietary requirements. The cook was aware of whom living at the home required a special diet; however, they sometimes tasked care staff with ensuring the food was correctly modified for the person. For example, they asked one care staff member to cut the crusts off a person's sandwich; however, this was not done and the person received and ate their food without the appropriate modification. This meant this person was at risk of choking and we reported this to the registered manager and reviewed the person's care documentation.

During our review of the person's individual care files, we identified they had been assessed by the speech and language therapy (SALT) team. The person had a medical condition and had been prescribed a category E diet where food should be sufficiently soft to mash with a fork. The person also required one-to-one supervision whilst eating. They had also been prescribed their drinks to be thickened and served in a spouted beaker. These measures were in place to prevent choking and aspiration. Different information included in the person's care files was conflicting and it was not clear how this person needed to have their food served. Observations at meal times and snack times showed us this person was not receiving their diet as prescribed by the SALT team. They were eating unsupervised, eating high risk foods, that were not suitable on a category E diet, and they were drinking out of a regular mug. Our concerns were such that we requested the registered manager put in place an emergency care plan that clearly documented the correct information for this person. This was put in place immediately and conveyed to all staff to ensure the person's safety whilst eating and drinking. We also requested the registered manager review the care plans for every person living at the home to ensure they were receiving the correctly prescribed diet.

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

As part of the inspection we looked at whether staff received training and the necessary support from the provider, such as, supervision and personal development, to enable them to carry out their duties competently. The registered manager did not have oversight of the levels of training of their staff. The registered manager was unable to produce an up-to-date training matrix that indicated staff were sufficiently trained to carry out their duties. We requested this information several times and received it sometime after the inspection. On review of the document we identified not all staff had received the required training. For example, four out of 23 staff had food hygiene training, five staff had training in pressure care and ten staff had training in DoLS. Additionally, we saw that no night staff had received fire marshall training to enable them to safely evacuate people from the home in the event of an emergency.

Staff members told us the training they had received was of a short duration and some were courses delivered together in one session. They told us the manual handling training was too short and there was insufficient time and this did not allow for all staff to practice using the equipment. This lack of robust training was demonstrated in the poor moving and handling we observed during the inspection.

The registered manager told us there was no programme in place for staff supervision and they rarely occurred. No staff appraisals or competency checks were carried out to check how well staff were performing their duties. Two staff members told us they had to pay for some of their training themselves.

The above concerns had been identified as a breach of regulations at the last inspection and a requirement notice was issued.

The above examples demonstrate a repeated breach of Regulation 18.2 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing

Eighty-five per cent of people living at The Vicarage were living with dementia. We looked to see if the physical environment reflected best practice in dementia care. At the last inspection we recommended that the service consider current guidance on dementia friendly environments. During this inspection we found the service had implemented a number of signs and photographs on doors to identify some rooms, such as bathrooms. However, we found no further attention had been paid to make the home's environment more conducive to people living at the home and reflect best practice in dementia care. There was no evidence of contrasting colours being used to aid independence and help people to orientate themselves around the home. Corridors had handrails which were decorated the same colour as the walls with no regard to differentiation of colour. Carpets were dark with a busy pattern, which may confuse or upset some people living with dementia. We signposted the team leader to available toolkits to utilise in order to conduct an assessment of the home's environment to help people living with dementia move around the home more easily.

We made a repeated recommendation that The Vicarage consider current guidance on dementia friendly environments to make the home more conducive to the people living at the home.

During this inspection we reviewed six people's personal care files to check if people were supported to maintain their health and well-being. We saw people were supported to access other health care professionals, such as the district nursing service and dieticians alongside other services, such as an optician. We spoke with one visiting professional who told us they had no concerns about the people living at The Vicarage. They told us when they visit people to provide nursing input that a care staff member will

accompany them during the visit and staff would always ring if they are concerned about the welfare of someone. They spoke highly of the registered manager and told us a communication book was in place for visiting professionals to pass messages on to care staff and vice versa.

Inadequate

Is the service caring?

Our findings

During this inspection we asked people and visitors for their opinions on how caring they felt the service was. We received mixed feedback, for example, one visitor told us, "The care is okay." Another visitor told us, "Staff seem to care." One person we spoke with told us, "Staff are very helpful." Another person told us, "Staff are okay."

During mealtimes and throughout the inspection we observed a number of interactions between staff and people living at the home. We saw some staff were kind and compassionate in the way they provided care and we observed instances where staff engaged with people and reassured them when providing assistance. For example, one staff member was sat holding a person's hand whilst they were singing together in the lounge. However, we saw a number of interactions where people were not shown respect and dignity. People were not always supported with care and kind attention.

Many interactions were quick and task-led; staff still did not have the time to spend encouraging, nurturing or try different approaches with people, for example, spending time to try and encourage someone to eat their meal. Staff told us they are so busy they do not have time to talk and they felt people were lonely. People's care records we reviewed did not include care plans around individual communication needs to help staff understand the needs and wishes of people who may require additional assistance with communication. Staff also told us they did not read people's care plans.

We observed several times where people were assisted to stand or transfer to a wheelchair. This was sometimes done without explanation or reassurance given to people. People were not always asked if they would like to do something; they were told what they were doing or where they were going. People were taken to the dining room and then back to the lounge; one staff member openly referred to the people who could walk as "The walkers". This meant that people did not have choice and control over their daily lives and were not referred to in a dignified manner.

We witnessed an incident during the inspection where one person was openly chastised by a staff member during one mealtime and was removed from the dining room. The person was clearly distressed during the incident. We reported this incident to the registered manager and requested they send a safeguarding alert to the local authority to conduct an investigation.

Some people wore clothes protectors during meal times. We found these were stored on unclean radiators in the dining room. The clothes protectors were worn, threadbare and in poor condition and not dignified for people to wear. People were served cordial at mealtimes in small, coloured plastic cups that did not appear appropriate for use by older people.

A 'bath schedule' was in place at the home. The team leader told us people had a choice but they were not offered a bath unless it was 'their day' to be offered one. The only bath people had access to was a very old sit up style bath as there was no regular-sized bath in the home. This 'bath schedule' did not afford people

dignity and choice. We observed not all the people living at the home looked groomed nor had their hair brushed. Staff told us people often have to wait when they request to go to the toilet as there is not enough staff on duty. One visitor told us, "[Name] is left too long before taking him to the toilet and he's sat in wet." These examples demonstrate that people's dignity at the home was respected.

We visited a small number of people's bedrooms and saw they were not always clean. People's bedding was old and in poor condition. We noted one person's bed had a ripped, plastic sheet covering a stained mattress. This did not promote people's dignity.
The above examples demonstrate a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Dignity and respect.

People's bedroom doors had a system where they locked on closure. We asked staff if anyone living at the home had a key to their bedroom door and they told us they did not; however, they said they could have one if they so wished, but no-one had asked for one. This meant people did not have free access to their own room and some people may also find it difficult to unlock the door from the inside and leave by their own will.

We asked three staff if they would like to have a family member living at the home and we received negative responses from all three staff.

During the inspection we noted several CCTV cameras were situated high on walls in communal areas of the building. We requested information from the registered manager on the rationale for the cameras, consultation and gaining consent from both the people living at the home and awareness of visitors to it regarding what policy was in place to ensure the lawful use of surveillance.. The registered manager did not produce for us this requested information and told us the CCTV was currently out of operation. The registered manager will need to ensure they are aware of and meeting their legal obligations around CCTV if they were to reinstate the system.

As part of our inspection we asked how equality and diversity was promoted at The Vicarage. The registered manager printed off and gave us a copy of their equality and diversity policy. On review of this policy we found the policy was around encouraging equality and diversity among the workforce and they would do this by providing training to staff. However, no equality and diversity training was offered at The Vicarage. We also noted the policy encompassed staff only and did not address the rights of people living at the home. This meant the equality and diversity rights of people living had not been considered or addressed at the home. Therefore, people were at potential risk of discrimination.

Inadequate

Is the service responsive?

Our findings

We reviewed six people's care documentation and found they included care plans and risk assessments; however, they did not include information needed to provide person-centred care. There was no information included on how the individuals, family members and other people were involved in developing and reviewing these plans. We did not see information around people's care choices; likes or dislikes, preferences or life history. People's social, culture and religious needs, hobbies, interests were not captured in the care plans we reviewed. People were not enabled to participate in planning their care choices or enabled to understand their care planning as no communication needs were recorded in plans.

The Accessible Information Standard denotes that information is required to be presented and communicated in such a way as to meet the individual needs of people with a disability, impairment or sensory loss. We did not find evidence throughout the inspection that attention had been given to assessing and meeting people's individual needs around accessing and understanding information.

During our inspection, we looked at the activities provided for people who live at The Vicarage. There was an activities programme displayed on the wall in the hallway of the home. We spoke with staff around the different activities displayed and they told us that despite the programme on display, these activities did not happen. The one activity provided on a regular basis was armchair aerobics in the lounge twice per week. We observed this activity during the inspection and saw that some people were enjoying the participation. However, some people had been asleep or watching television in the lounge prior to the activity commencement and there was no alternative quiet lounge area.

People living at the home and visitors told us there was little in the way of activities. One visitor told us, "I wish there was more. There are no magazines. No stimulation." One person told us they don't really do anything and they spend their time in the lounge or dining room having meals. Staff confirmed people are taken from one area to another during the day so they can be supervised which was driven by the needs of the staffing not the individual needs and choice of people.

Other than the armchair aerobics people were mainly sat in the lounge area with nothing to do. There were no personalised activities on offer at the home. We did not see magazines or newspapers available for people to read. Research has shown that people who are not given to the opportunity to participate in meaningful activity have a poorer quality of life. The National Institute for Health and Care Excellence (NICE) has produced a number of quality standards to optimise the mental wellbeing of older people in care homes and promote that "Older people in care homes are offered opportunities during their day to participate in meaningful activity that promotes their health and mental wellbeing."

On arrival on the first day of our inspection at 7.30am we found several people in the dining room having breakfast. We also noted during a review of night shift records it was recorded that a number of people were up and dressed early in that day at approximately 5 to 5.30am. We spoke with the team leader around our concerns of how early several people were up and ready for the day and they told us it was people's

choice. However, one staff member told us people are asked to get up early between 6 and 7am and gave examples of people who are not happy to rise for the day at this early time.

The registered manager told us no-one at the home was currently receiving end of life care. There was no policy and procedure in place at the home to support people at the end of their lives. This meant people may not be adequately supported if they wished to stay at The Vicarage for their end of life care.

We found the registered manager and staff were not aware of people who had a Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) in place to direct staff actions in the event of an emergency. Staff we spoke with did not understand what DNACPR meant for people. To safeguard and respect people's wishes, we reviewed all care plans and compiled a list of people who had a DNACPR in place. We gave this to the registered manager during the inspection and requested that they ensured all staff were aware of the implications of these documents.

The above examples demonstrate a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care.

As part of our inspection we looked at how complaints were responded to and managed at the home. There was a complaints book in place that detailed action taken as a result of complaints. We also saw there were a number of compliments in thank you cards where people had expressed their gratitude for the care received. However, there was no information displayed around the home on how a person or relative could make a complaint. There was no resident handbook or welcome pack given to people on admission to the home. We spoke to the registered manager about the lack of accessible information available to people to enable them to make a complaint about the service if they wished. They told us information was printed in the home's statement of purpose; however, this document was not given to people or accessible to people living at The Vicarage. The registered manager told us people could request a copy of the statement of purpose if they required one; however, people were not made aware of this. Therefore, people did not have access to the procedure regarding making a complaint and to whom.

This a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Receiving and acting on complaints.

Inadequate

Is the service well-led?

Our findings

The home had a manager in post who had been registered with the Care Quality Commission (CQC) since October 2010 at this location.

A registered manager has responsibility under their registration with the Care Quality Commission to have regard, read, and consider guidance in relation to the regulated activities they provide, as it will assist them to understand what they need to do to meet the regulations. We found that the registered manager did not have knowledge and documentation that showed us they were aware of their obligations. We identified three continued breaches and two further breaches of the regulations during our inspection. We also identified three breaches of the registration regulations.

The previous inspection rating was present on the home's website as is their requirement. We found the last CQC rating was not displayed in the home to inform people and their visitors around the outcome of the previous inspection. This is a requirement of registration with CQC.

This is a breach of regulation 20a of the Care Quality Commission (Registration) Regulations 2009.

Statutory notifications to inform us of significant incidents at the home had not been submitted to CQC as required since 2016.

This is a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Statutory notifications to inform us of the death of a person had not been submitted to CQC as required since 2016.

This is a breach of regulation 16 of the Care Quality Commission (Registration) Regulations 2009.

We requested a copy of the safeguarding adult policy and procedure. However, this was not produced for us during the inspection. There was no safeguarding investigation file and the registered manager told us that no safeguarding incidents had occurred at the home. Statutory Notifications had not been sent in informing CQC of safeguarding incidents at the home since 2012. We witnessed an incident during the inspection where a person was not treated with dignity and respect and we requested the registered manager make an immediate referral to the local authority safeguarding team; however, we were aware they did not report this for some time after the inspection and did not report through the correct channels. This demonstrates a lack of understanding and awareness of their responsibility to safeguard the people living at The Vicarage. The registered manager did not have the required policies and procedures in place to ensure people were safeguarded from the risk of abuse.

We found there was a lack of oversight and inadequate monitoring of the quality and safety of the service provided. We did not find any evidence to support that existing governance systems were being effectively

utilised to assess, monitor and improve the quality of the service on a regular basis. Operational checks had not been completed regularly and training for staff was not up to date. The registered manager did not have robust monitoring systems in place to ensure people were receiving safe and effective care that adhered to a number of pieces of legislation, such as MCA and DoLS.

There had been a survey conducted in March 2018 with people and their relatives to see how satisfied people were with the service provided at The Vicarage. However, these surveys were not anonymous and people's names had been written on the top. The majority of the feedback indicated people were satisfied living at the home. We saw a number of positive comments from people mainly around staff. We also saw where people had expressed dissatisfaction in some areas, these included; lack of activities and no staff in the lounge. There was no evidence this feedback had been analysed, acted upon and changes made to the service as a result.
Personal information around people who lived at the home was not kept confidential and therefore systems did not adhere to the Data Protection Act 1998. Personal information, such as, care plans, were stored in the open office on desks or in unlocked drawers. This meant that personal, private information was not kept secure and may be accessible to anyone living at or visiting The Vicarage.

The registered manager did not have support structures in place to provide effective management of the service. They were also the registered manager of another similar sized home in Tameside and worked at the home part-time. A reliance was placed on the team leader to manage the home in their absence. There was no administrative support at the home. The registered manager does not attend staff handovers, hold team meetings or conduct any walk rounds of the home to evaluate the environmental or operational running of the home.

The registered manager was also the provider and nominated individual for the service. There was no contingency plan to manage both homes in the event of the absence of the registered manager.

We found widespread concerns with care and support delivery at the home as outlined in this report. We also referred our concerns to the local authority during the inspection. These shortfalls had not been identified or acted upon by the registered manager despite us raising these concerns directly with them. We found the culture throughout the organisation was not centred on people's choice and preferences; this was demonstrated in the examples of poor care we observed throughout the two days of inspection.

Throughout the inspection we fed back our findings and the identified concerns. We did not receive assurances that the shortfalls would be addressed and any remedies were implemented at our request.

We also requested specific information on several occasions; however, the registered manager did not always provide us with reassurances or the information we had requested. We gave the registered manager the opportunity to provide us with assurances and information within seven days after the site visit. However, we did not receive the information until 20 days later and not all information was received. This meant the registered manager was not taking immediate steps to mitigate the highlighted risks to people from our inspection findings.

The above examples demonstrate a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.