Central England Healthcare (Stoke) Limited

The Old Vicarage Nursing Home

Inspection report

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13 January 2016

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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

This inspection took place on 12 and 13 January 2016 and was unannounced. At our previous inspection in January 2015 we had concerns that people were not receiving care that was safe and effective. We found two breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and asked the provider to improve. At this inspection we found that no improvements had been made and there were further breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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 Old Vicarage Nursing Home provides accommodation and nursing care for up to 45 people. There were 43 people using the service at the time of this inspection.

There was no registered manager in post. 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. We were supported throughout the inspection by the provider's nominated individual.

The provider was not working within the guidelines of the Mental Capacity Act 2005. The MCA and the DoLS set out the requirements that ensure where appropriate decisions are made in people's best interests where they are unable to do this for themselves. People were being unlawfully restricted of their liberty within the service and were not consenting to their care.

People were not protected from the risk of abuse. Incidents of suspected abuse were not reported or investigated.

People's medicines were not managed or administered safely.

People did not always receive the health care support they needed. Staff felt supported and trained however this did not always reflect in their care practices.

People did not receive care that was personalised and reflected their individual needs and preferences.

People were not always treated with dignity and their privacy was not always respected.

People knew how to complain but complaints were not always managed appropriately.

No improvements had been made since our previous inspection and the systems the provider had in place to monitor the quality of the service were ineffective.

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. People were not safeguarded from abuse or the risk of abuse. Risks to people were not minimised following incidents that resulted in harm. People's medicines were not managed safely. There were insufficient staff to keep people safe.

Is the service effective?

Inadequate

The service was not effective. People did not always consent to their care, treatment and support. The provider could not be sure that people's nutritional needs could be met. People did not always receive the health care support they needed. Staff felt supported and trained however this did not always reflect in their care practices.

Is the service caring?

Inadequate

The service was not caring. People were not always treated with dignity and respect. People's privacy was not always maintained.

Is the service responsive?

Inadequate

The service was not responsive. People did not receive personalised care that reflected their needs and preferences. Complaints were not always addressed and action was not always taken to improve people's experiences.

Is the service well-led?

Inadequate

The service was not well led. There was no registered manager in post. Systems the provider had in place to monitor the quality of service were ineffective and improvements had not been made since our previous inspection.

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.

The inspection took place on the 12 and 13 January 2016 and was unannounced. The inspection was undertaken by two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed the information we held about the service. This included notifications that we had received from the provider about events that had happened at the service. These are notifications about serious incidents that the provider is required to send to us by law. We had also received information of concern from several sources prior to the inspection.

We spoke with 16 people who used the service, four relatives and four care staff, two nurses, the nominated individual, operations manager and a visiting nurse.

We observed care and support in communal areas and also looked around the service.

We viewed six records about people's care and records that showed how the home was managed including quality monitoring systems the provider had in place. We looked at staff rota's and medication administration records for several people.

Inadequate

Is the service safe?

Our findings

People were not safeguarded from the risk of abuse. Although staff told us they would report any alleged abuse to a senior member of staff we saw that not all staff recognised signs of abuse. We observed one person who used the service slap another person at the breakfast table. The staff member present did intervene and remove one person from the table but this was not recorded as an incident of abuse. The staff member informed us that there were often 'little' arguments between people. We saw on another occasion it was recorded that one person had verbally and physically abused another person and they had complained they had been hurt. This had been reported to the operations manager who told us that they had not raised it as a safeguarding alert.

One person who used the service told us that they had reported that a member of agency staff had abused them. This member of staff had never worked with this person before and had been asked to support them with their personal care. The person had told a member of staff who had informed the manager at the time. No action was taken to report or investigate the abuse. The person informed a visiting social worker who raised the incident with the safeguarding team for further investigation. The person told us: "No one from the home has been to speak to me about it or offered me an apology". This was confirmed by the operations manager.

These issues were a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that one person had been assessed as being at high risk of falls. We saw records that confirmed that they had been found on several occasions having fallen in their bedroom. On one occasion they had fallen and hurt their back on the iron rail on their bed. The bed remained in situ and no action had been taken to prevent any further injury from the iron rail on the bed. We saw records that confirmed that a falls mat had been put in place to alert staff if the person was getting out of bed. On the day of the inspection the person was in bed, and the mat was under the bed and unplugged. The nurse told us that the person didn't need the mat any more. However the person had recently experienced a fall and was still assessed as being at high risk of falling. Later in the day we found the person being supported to stand in the door way of their bedroom by a domestic staff member who asked us to call for a carer to support the person, they had not called their call bell prior to mobilising. This meant that this person was at risk of falling and injuries as equipment to keep them safe was not being used.

We heard a person calling from their room. We found them in bed with bed rails on the bed and a crash mat on the floor. The window was open and they had a sheet on them. They told us they were cold so we shut the window. The person had no way of calling for help as the call bell was out of their reach and was not in working order. We looked at the care plans for this person and saw that they had been regularly found on the mattress on the floor having climbed over the bed rails. The person's care plan had been regularly reviewed and the incidents had been noted, however nothing had been done to reduce the risk to the person and the bed rails remained in place. We observed and staff confirmed that this person regularly attempted to climb over the bed rails. This person was at serious risk of harm due to them attempting to

climb and falling onto the floor.

We found two other people being cared for in bed with no call bells at reach for them to be able to call for assistance. We called one person's call bell at the central point on the wall as they were saying they were hungry. Staff did not respond to the call bell. We found the call bell system was faulty and that this person's room was not identifiable on the system. This meant that these people were at risk due to not being able to call for assistance if they required it.

At our previous inspection in January 2015 we found that people's medicines were not managed safely. At this inspection we found that no improvements had been made. We saw that one person was drinking a prescribed food supplement that was prescribed for someone else. We found external creams in people's rooms with no prescription labels on them so care staff could not be sure they belonged to the person. Nurses were signing to say the care staff had administered the creams but told us they could not be sure that this had been completed. We saw gaps in recordings of when medication had been given. We found several bottles of prescription bathing oils and shampoos with no names on in the bathroom. A member of staff told us: "They were prescribed for people who are no longer here". This meant that the provider was not returning prescribed items when they were no longer required. There were still no PRN protocols in place for the nurses to be able to follow to give people their medication when they needed it in a safe manner. PRN medicines are prescribed on an 'as required basis'. We found that one person had been administered PRN medication when they may not have needed it.

These issues constitute a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us and we saw that there were insufficient staff to keep people safe. People being cared for in their bedrooms spent long periods of time without staff support. We observed people calling out for support and we saw that staff were not always in the vicinity to hear them calling. We observed that two people were calling out for over an hour before staff were able to attend to them. A member of staff told us: "By the time we've gone round when we get to the last people, they are often soaking wet or soiled, we are just so busy".

Everyone was being supported to reside in one lounge area downstairs. The lounge was full with not enough seats for everyone. There was an upstairs lounge that was out of use, the operations manager told us that they closed it as they couldn't staff it, and that people's safety was being maintained in the one lounge. Another person living with dementia was constantly seeking staff support. We saw that staff did not have time to go to them which meant they were being asked to wait or sit down. The operations manager told us that the staffing was based on a one staff to five people ratio, however people's individual needs had not been considered when setting the staffing levels.

This constitutes a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

One person asked to speak to us and told us that they were unhappy with their care at the service. They told us they wanted to leave. They said: "I thought this would be the best thing for me and it's the worst". We discussed this with the nurse in charge and they told us that this person had mental health issues; however the nominated individual told us they did not. The person did not have any family and the staff had not sought external support to advocate for the person or act upon their requests to leave.

The provider was not following the guidance of the Mental Capacity Act 2005 (MCA). The 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's capacity to consent had been assessed but consideration to people being involved in specific decisions had not been made. Staff caring for people were unsure whether people had capacity and were making decisions on their behalf. One person who we were told had capacity was not involved in the decision about having a Do Not Attempt Resuscitation order put in place, instead their relatives were asked if they would like one put in place.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). People were being unlawfully restricted of their liberty through the use of bed rails and other restrictive practises. The nominated individual told us they were aware that more DoLS referrals needed to be made. Staff told us that one person became anxious and attempted to hurt staff when they supported them to get them out of bed. Some staff told us that they did get the person out of bed a couple of times a week and it took four staff as the person sometimes tried to throw themselves out of the hoist. The person's risk assessment stated 'currently nursed in bed as not safe on hoist. Physically aggressive, and agitated during transfers'. No external professional had been contacted for support and advice about safe ways of transferring the person and no Deprivation of Liberty referral had been made to the local authority to legally restrict the person in their best interest. This meant that this person was being unlawfully restricted.

We saw a care plan and staff told us that this person scratched staff when being assisted with personal care and mobilising. The person's care plan stated that 'in their best interests a towel or blanket can be placed in between [Person's name] hands and staff to cut the person's nails. Staff told us that this person was resistive to this intervention. No DoLS referral or multi agency decision had been made to ensure that this procedure was in the person's best interest.

These issues constitute a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider could not be sure that people's nutritional needs were being met in a safe way. One person had been assessed at high risk of malnutrition and prescribed food supplements. They should also be

offered fortified milky drinks throughout the day and required a soft diet. Records confirmed this person had not had their weight monitored for three months. We observed the person through the day and saw they were not offered any food supplements or fortified drinks. The nurse told us that the carers were responsible for giving people their prescribed food supplements. The carers and the nominated individual stated it was the nurse's responsibility to give people their supplements. We later saw this person lying down eating a piece of toast in a position that would compromise their safety whilst eating. This person's care plan stated that they should be offered a soft diet and when eating they should be sat up and in a chair. This meant that the person was at risk of further malnutrition and choking.

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

Staff we spoke with told us they felt supported even though they had several changes in management. Training was on-going and the nurses told us they were being supported through their revalidation .Revalidation allows nurses and midwives to demonstrate that they practice safely and effectively and requires the nurse to spend time completing assessments and collecting evidence to support the revalidation. However some of the staff lacked knowledge in the mental capacity act and didn't always demonstrate a positive value base. There was no clear leadership and direction offered to staff whilst completing their duties which led to some poor practice being observed.

People saw their GP when they were unwell and some people had input from health professionals when they required it. However some people would have benefitted from the support from other health care agencies. For example one person required health care advice as their behaviour was preventing them from being able to get out of bed. Another person required a review of their medication as they were asleep at the times it was prescribed and often didn't take it. This meant that people's health care needs were not always met.

Inadequate

Is the service caring?

Our findings

We received mixed views from people who used the service about the way they were treated. Some people told us the staff were kind and caring whilst others did not. One person told us: "Some [staff] are better than others, some are abrupt". We saw a nurse offering a person their medication on a piece of tissue. The person asked for their glasses as they were unable to see the tablets and they were lying down in bed which made it difficult for them to see them. The person eventually said they couldn't do it and the nurse responded by saying: "Just do it". This person was not treated with dignity and respect.

Two people we saw complained of being cold. Both people were in bed with their bedroom windows open and they were unable to shut them. One person told us "I'm frozen". We asked them if they wanted their windows shut and they did. Other people were in bed with duvets on but no duvet covers on them. People were not being treated with dignity and respect and attention to detail was not evident in the care being provided.

At lunchtime we observed that one person asked what was for lunch. A member of staff responded by telling them: "I don't know we'll see when the trolley comes". When the meal came we saw a member of staff verbally offering a person two choices'. The person was unable to understand what the choices were so the staff member just became louder and eventually gave them one of the choices. The person did not eat the meal, and was offered toast as an alternative which they ate. We saw one person poured tea all over their meal which went unnoticed by staff. We saw staff walk past another person who required support with eating and put a spoonful of food into their mouth and walk off and then repeated this. When some people who used wheelchairs had finished their meals they were taken away from the table by staff without staff communicating with them as to what they were doing or where they were going. One person was waiting for some toast and a staff member began to wheel them away from the table. The person stopped them as they wanted to finish their breakfast.

Several people spent time on bed rest during the afternoon. We saw people were on their beds with the bedroom doors open. One person was naked from the waist down and distressed. They were clearly visible to anybody who walked past their room. This person's privacy was not being respected.

These issues constitute a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people looked unkempt. They had long dirty fingernails and their hair had not been washed or brushed. One person had dirty clothes on. We asked a nurse about this person and they told us that they didn't know why this person looked like this as they were generally clean and tidy.

Within one bathroom area we saw a range of toiletries. Some were named and others were not. A staff member was not able to tell whose they were and why the named ones had not been returned to people's bedrooms. This meant that people's belongings were not being respected.

Inadequate

Is the service responsive?

Our findings

People did not always receive care that was personalised and responsive to their needs. We saw that one person asked for toast at breakfast. A staff member presented them with the toast and they asked politely for the crusts to be cut off as they liked their food soft. The staff member said: "It is soft" in an abrupt manner and took the toast away to cut the crusts off without further interaction. The person looked visibly distressed at the staff member's attitude and began apologising for having to ask. We looked at this person's care plans and saw that they had low self-esteem and also needed encouragement to eat. The interactions with the staff member did not promote either this person's esteem or their nutritional needs.

We observed one person calling out for staff. They were sitting in the lounge where other people were involved in an activity they were unable to join in due to their dementia. The person was constantly calling for staff's attention and sounded distressed. Care staff present responded by asking them to wait or sit down if they attempted to stand. No other activity or staff support was offered to meet this person's needs or preferences. The nominated individual told us this person and some other people's needs required reassessing to ensure that they could be met at the service. This showed that people's needs were not being constantly assessed and reviewed and the provider was not ensuring that they could meet people's individual needs.

People's care plans were not always up to date and reflective of people's current needs. One person's care plan stated they could mobilise with a frame, however we saw that staff now had to support the person with a stand aid and wheelchair. This person's needs had changed significantly over a short period of time, however the care plans and risk assessments had not been reviewed to reflect the changes. This person was at risk of receiving care that was unsafe. It was recorded in one person's daily records that they had a recent pressure area which required dressing. There was no wound care plan for staff to be able to follow and ensure the person's needs were met. This meant that these people were at risk of receiving care that did not meet their individual needs.

These issues constitute a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

There was routine and structure in place which meant that care was not being delivered in a way that met people's preferences. There was one lounge area in use in the service, a second lounge was out of use. We were initially told it was awaiting refurbishment and later told it was closed due to staffing issues. A relative told us that the lounge had been closed for a few months and that their relative now missed the opportunity to sit in the upstairs area with their spouse. We saw everyone who was not being cared for in their room or did not have the capacity to choose was transported to the one lounge downstairs. The lounge did not have enough space or chairs for people. An activity of bingo took place and people were not offered the opportunity not to be in the lounge area whilst it took place. The lounge was crowded and visitors were also visiting in the lounge as there was no private area for them to go to. One relative told us: "There is no private room to visit now, we have to sit in the main lounge or the bedroom, where there are not enough chairs or room".

A member of staff told us that the night staff 'insisted' on people being in bed at 8pm. We discussed this with the nominated individual who confirmed that they had discussed this with the night staff previously. This meant that people's preferences were not being considered and responded to.

People knew how to complain but two people told us that their complaints had not been taken seriously. One person had complained about a member of staff and had made an allegation of abuse. No one from the service had been to speak to the person about this incident and they felt it had not been taken seriously. A relative told us: "I wrote to the complaints team about six weeks ago about the use of the upstairs lounge and I have not had a response as yet.

Annual quality surveys were sent out to all people who used the service and their relatives. The last one had been undertaken in March 2015. The information from these was analysed and an action plan put in place but had not been implemented . The nominated individual told us that due to a lack of consistent manager any identified improvements had not been made.

Inadequate

Is the service well-led?

Our findings

There was no registered manager in post. The nominated individual told us that there had been three managers in post since the last inspection all of whom had resigned. The service was being managed by the nominated individual two days a week and an operations manager three days a week. On the second day of the inspection a person was interviewed and offered the post of manager.

No improvements had been made since our inspection in January 2015. An action plan had been drawn up but any actions to improve had not been completed. The nominated individual showed us systems that the provider had in place to support any future registered manager with monitoring the quality of the service. However these had not been used effectively over the last 12 months due to the change of management and had not been implemented by the nominated individual.

Risks to people were not being consistently identified, managed and reviewed. Some people's welfare and safety was not promoted and their current care needs not taken into consideration. People's individual needs were not assessed and reviewed to ensure that the service being provided met their individual needs. The provider had not undertaken appropriate audits and checks of care plans and risk assessments to make sure that people received safe and appropriate care. This meant that people were receiving and at risk of receiving care that was unsafe.

We saw that a social worker had reviewed one person's care in September 2015. They had requested that the staff applied for a DoLS authorisation. At the time of the inspection this had not been completed. We found that several people were being deprived of their liberty unlawfully. The nominated individual recognised that referrals had not been made.

Safeguarding referrals had not been made to the local authority when there had been incidents of abuse. We saw an incident where people were at risk of harm and were being assaulted by other people. Investigations were not carried out to reduce the risks to people. People were at risk of and had been abused by other people who used the service.

A medication audit had been completed in October 2015 by the nominated individual. It had identified the issues we had identified as requiring improvement at this and the previous inspection. No action had been taken to make the improvements and concerns in relation to medicines remained the same since January 2015.

The nominated individual informed us that they allocated staffing hours based on a five person to one staff member ratio and this was how the staffing levels were applied through all of the providers service. Staffing levels had not been assessed based on the individual needs of people who used the service and we saw that people did not receive care in a timely manner due to the lack of staff. This meant that the system in place to assess the staffing hours required were ineffective.

These issues constitute a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.