Mr William Dunnett Jackson

The Old Vicarage

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on the 15, 16 and 21 November 2016 and was unannounced. We previously inspected the service on the 19 November 2015 and rated it as Requires Improvement. This was due to concerns in respect of whether the service was Safe, Effective and Responsive. In particular we found the service was not assessing people in line with the Mental Capacity Act 2005 (MCA) and ensuring they were not depriving people of their freedoms without the necessary authorisations being in place. People's records were not always completed by staff nor did they reflect people's current needs. Parts of the home required maintenance and repair which was placing people at risk of infection. We found improvements in respect of these. However, records remained an issue.

The Old Vicarage is registered to provide personal care and accommodation for up to 19 older people. It is not registered to provide nursing care; if this is required it may be provided by the community nursing team. On inspection, there were 17 people registered to live at the service but one person was in hospital.

A registered manager was appointed to manage the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered provider and manager had failed to ensure people were adequately protected from accidental harm. There were no systems in place to stop people burning themselves on the heaters. The hot water was known prior to this inspection to have been reading in excess of the 44oC maximum recommended temperature. Windows were not being restricted to the recommended maximum opening of 100mm. During the inspection we were informed a person had been seriously hurt after coming into contact with one of the heaters. These concerns are currently being investigated. The registered provider and manager were requested to take immediate action to protect people and this action has now been completed.

The registered provider and manager had failed to notify CQC about serious matters affecting people who live at The Old Vicarage, such as serious injury. Prior to the inspection our records showed there had been no information about significant injuries between 2014 and 2016. These are matters registered people are required to tell us about. These have been sent in retrospectively.

There were not enough staff to meet people's needs safely. Systems were also not in place to make sure there were enough staff. During the day and night time there were insufficient staff to meet people's needs safely or in a timely way. At night time, those people who needed two staff to assist them safely either received assistance from one member of staff (placing the person and themselves at risk of harm) or alternatively they had to wait until the following morning when a second member of staff was available. We requested the registered provider and manager took immediate action to address the staffing at night and review the day time staffing. The provider did not commit to the increased staff numbers but said that

staffing would be reviewed

Staff told us they felt they could approach the registered manager and could suggest changes in how the service was run but did not feel they were heard. Staff told us they had spoken about the staffing to the registered manager and in staff meetings but they had not been listened to.

People had risk assessments in place in line with the risk of falling, skin breakdown, malnutrition, and being moved by staff. These were updated at monthly intervals and linked to their care plans. There were no risk assessments in place in respect of people's individual needs where they were at an increased risk. For example, there were no risk assessments in place for people at risk of choking. People's accidents were collated and reviewed for the individual but there was no whole home assessment of these falls and accidents to see if learning could take place.

Staff were trained in how to meet people's needs in the event of a fire; a contingency plan was in place and a place of safety in the community identified. People had personal emergency evacuation plans (PEEPs) in place. However, there was no evacuation equipment in place and remedial action identified in a fire risk assessment in September 2015 had not been carried out. We have referred these concerns to the fire service to review.

Medicines were administered by staff trained to complete this task. Staff competency was being checked to ensure they understood the training and were maintaining safe practice. All medicines were stored safely and securely. People had their medicines as prescribed and records of this were kept in their Medicine Administration Record (MAR). An audit was completed but there was no check of amounts of medicines to ensure these were accurate. We have recommended the registered provider and registered manager ensure the management of medicines is in line with the current guidance.

The service was clean and people told us they were happy their rooms were kept clean. Not all staff had been trained in infection control. We identified that infection control practices were not always being followed. We have recommended the registered provider and manager review the latest infection control guidance to ensure the policy and practice reflects this.

Remedial work had taken place since the last inspection to address the concerns about the maintenance of the service that was placing people at risk. The registered manager had systems in place to ensure the equipment was safely maintained.

People's needs were assessed before they moved into the home and care plans were drawn up, giving staff information about their general needs. Care plans were personalised, explaining how people wanted staff to assist them with personal care tasks. However, the plans did not provide sufficient detail about people's health needs such as dementia, diabetes or heart conditions. End of life care had not been planned and their wishes had not been recorded. This meant people could not be certain they would receive the care they needed or wanted at the end of their lives.
Activities were provided for people to take part in. This depended on the availability of staff to have time outside of the tasks that needed completing. A recent residents' meeting had requested more one to one time with staff. Staff told us they were restricted by time in meeting this request.

The recording of people's capacity and their ability to consent to their care and treatment had improved since the last inspection. Staff had received training in Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and described how people's needs should be met if they lacked capacity or had a DoLS assessment requested. Assessments had been carried out to identify any aspects of people's lives

where they did not have capacity to consent. Staff supported people to make decisions and give consent where possible, although this had not always been recorded clearly. The registered manager agreed to review this and make sure the records were clear.

We could not be certain that staff had received sufficient training to meet people's needs safely because there were significant gaps in the training records. Staff who started in 2016 had not had safeguarding vulnerable adults training, for example. We spoke with the registered manager who acted promptly to ensure staff training needs were identified, planned and recorded.

People using the service said they felt safe. Staff were knowledgeable about safeguarding people and keeping them safe from abuse. Staff were recruited safely. People and their relatives felt the staff were caring. All staff we spoke with worried about not being able to be as caring as they would like due to there not being enough staff. Staff were observed being respectful in the way they spoke with people and spoke kindly and patiently to people when this was needed. People were spoken to with politeness and staff told people what they were doing before they did it.

People's need to have enough to eat and drink were met. People said they had enough to eat and drink. People had fresh jugs of water or juice in their rooms or available through the day. People were provided with drinks when they wanted them. People could choose what they wanted to eat and were complimentary about the food and the portion sizes. People who were at risk of weight loss were referred to specialist health professionals for assessment and support and staff followed any guidance they received.

People's health needs were met. They could see a range of health professionals and their GP as needed. They had regular appointments with chiropodists, opticians and dentists.

People knew how to complain and raise a concern. People and their family were asked their view of the service. People said they attended resident meetings. Questionnaires were sent out to be completed by people, family and professionals once a year. The feedback for the one completed last time was very positive.

We found breaches of the regulations. You can read the action we have told the registered manager and provider to take at the back of full report.

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.

We are considering our actions in line with CQC's enforcement policy. We will publish a further report that details what action we have taken at a future date.

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.

The registered manager and provider had not protected people from the risk of burning themselves on the heaters, from scalding or from falls from a height. The provider took action when requested.

There were not enough staff to look after people safely.

Peoples' medicines were given to people safely. Audits were not ensuring stocks of medicine were recorded.

The service was not fully meeting the requirements in relation to Infection control.

People benefitted from robust recruitment and safeguarding processes that ensured people were protected from the risk of abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not always trained to complete their role effectively.

People were assessed in line with the Mental Capacity Act 2005. However, the registered manager and provider were not making sure the recording of this was clear. This was not Staff understood the need to seek people's consent to care and treatment.

People received meals which met their dietary needs and took account of their preferences.

People's health needs were met.

Is the service caring?

Requires Improvement

The service was not always caring.

People were cared for at their end of life. However, people's wishes and choices had not been recorded. The registered manager addressed this during the inspection.

People and their visitors felt the staff were caring.

People felt staff maintained their dignity. Staff were heard speaking to people respectfully.

People felt in control of their care and key workers were allocated to support this.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were assessed on coming to live at the service and they had care plans in place so staff knew how to meet their general needs although some specific health needs were not adequately planned.

Staff were not always responsive to people's changing needs due to poor communication systems.

Activities were provided but depended on staff being available. Staff said they did not always have time to do this.

People knew how to complain. There was a complaint process in place and people's complaints were reviewed.

Is the service well-led?

Inadequate

The service was not well-led. The provider needed to address whether they were registered correctly with us.

The provider and registered manager did not have systems in place to ensure the safety and welfare of people.

The provider and registered manager had failed to notify the relevant agencies of serious accidents and incidents in accordance with their legal requirements.

People, staff, relatives and professionals were invited to give their views on the service, but they could not be confident these would be listened to or acted upon.

The Old Vicarage

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 15, 16 and 21 November 2016 and was unannounced.

The inspection was carried out by one inspector 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.

We spoke with 12 people using the service and four of their relatives. We followed the care of four people in detail to check they were receiving the care as planned. We did this by reading their records and speaking to them. We observed how staff interacted with people.

We spoke with five staff, read three staff personnel files and reviewed staff training records. We spoke with two directors of the company which manages the service and the registered manager.

During the inspection we spoke with three district nurses and the local authority safeguarding team.

Inadequate

Is the service safe?

Our findings

On day two of the inspection we were made aware of an incident following which a person using the service sustained a serious injury from a storage heater. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident.

However, the information shared with CQC about the incident indicated potential concerns about the management of risk. People were not fully protected from risks to their health and safety. The provider had failed to ensure people were protected from heated surfaces, the risk of scalding and the risk of falling from a height.

The home used storage heaters but these had not been covered to reduce the risks of burns if people came into contact with the hot surfaces. We found heaters in people's rooms, communal areas and corridors had not been protected. This inspection examined those risks.
Action had not been taken following this person being injured other than to turn their individual heater off. The risk to others had not been considered.

People were at risk of scalds from hot water. When we asked to see records for the water temperatures, the registered manager told us she knew "they are too hot". Readings of the hot water in people's ensuites were taken on a regular basis and recorded as reading "above 50oC". When we took the water temperatures on the 21 November 2016 they ranged from 51.4oC -62.5oC which was putting people at the risk of scalding. This affected sinks where hand and body washing took place and three baths. Only the communal toilet, main bathroom and main shower tested at below the 44oC limit recommended to reduce the risk of scalding by the Health and Safety Executive (HSE). No action had been taken by the registered manager or provider to put systems in place to protect people from scalding despite being aware of the risk.

People were at risk of falling from unrestricted windows. The windows in the service had not been restricted to the HSE recommended limit of 100mm. No risk assessment or audit of the windows had taken place. This placed people at risk of falling from a height which could cause injury.

Not having these measures in place was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We requested the provider and registered manager take immediate action to prevent people being at risk from the heaters, hot water and falls from a height. We also requested they take immediate action to protect people from the heaters and review every person in respect of their likelihood to come into contact with the hot surface while remedial action could take place. On the second day, we were advised people's rooms had been rearranged to reduce the possibility of their accidentally coming into contact with the hot surface. Following the inspection we were advised covers for the purpose of protecting people were secured over the heaters; windows were restricted to not open more than 100mm and valves were fitted to the hot water to control the temperature to read below 44oC. The heaters, window restrictors and water would then be reviewed monthly to ensure people continued to be protected.

There were insufficient staff to meet people's needs safely. Prior to the inspection, concerns were raised with us in respect of the staffing of the service. We were told one member of staff was on duty at night and two were deployed in the day. Equipment that should be operated by two staff in line with safe manual handling practices was being used by a single member of staff at night. This included slide sheets, hoists and stand aids.

We found the service lacked the staffing to meet people's needs safely. At night there was one member of staff on duty. We reviewed four people who currently required two staff at all times to meet their needs. We found their care plans clearly stated they required two staff to meet all their needs during the day. Staff confirmed at night they would turn people in bed, use the stand aid and hoist people on their own as they had been told they could do this safely by the registered manager and provider.

We were told by the registered manager and provider that a senior staff member was available at the end of the phone to give advice and a "sleeper" was on call. The sleeper was the registered provider who lived next door. Staff told us they did not call on the sleeper and felt they were encouraged by the registered manager and provider to meet people's needs themselves. Management stated this was not the case. Rather, this had been reiterated to staff in their lone worker policy and had been reinforced at a staff meeting.

We asked the registered manager and provider how they knew they had enough staff to meet people's needs at night and in the day time. We were advised there was no audit of people's dependency on staff for some time, call bells, falls or any other means to ensure the staffing reflected the needs of people living at the service. There was also no evidence that staffing was flexible to meet needs that may change on a daily basis. Records of staff meetings showed staff had raised staffing as a concern but this had not been acted on.

Records showed that in July 2016 a trainer in manual handling had spoken to the registered manager to raise a serious concern about unsafe moving and handling procedures. They had expressed concern that staff were working single handed when using equipment when current safe working recommendations meant this should be carried out by two staff. Staff had told the trainer there was only one staff at night. The trainer had told the registered manager they felt this to be unsafe but no action had been taken to address these concerns. The registered manager followed up this concern by discussing the specific moving and handling procedures employed with respect to one person with an occupational therapist to ensure that they were appropriate. However, records showed this person's condition had changed since this time and there had been no review of this advice. This meant staff and the person were increased risk of harm.

One persons' care plan (all completed and updated across 2016) described them changing to being cared for in bed as their condition had progressed. They had a slide sheet and hoist provided to meet their moving needs in the day time. Their moving and handling care plan stated, "I require the support of two carers and a slide sheet to sit me up in bed and reposition me at least every two hours". They were also noted as, "high risk of developing pressure sores" in their skin management care plan. A nursing assessment in August 2015 stated this person lacked the mental capacity to make choices or decisions about their care. They were also not always able to "engage with care and support due to their cognitive function" and, "Cannot co-operate with movement when asked [and] is unable to change position" by themselves. In a further skin integrity care plan written in September 2016 it stated, "As [the person] is light and can partially help to reposition [themselves] this can be done by one carer at night". We spoke with the district nurse who confirmed they would have expected two staff to be moving this person at night due to their high risk of skin damage. Staff confirmed they were moving the person by themselves without a slide sheet. This was placing the person at a higher risk of skin tears.

We heard the same person calling out from their bedroom and went to see them. We informed a member of staff who was doing a quiz in the lounge. They said, "She always does that. She wants company, it's because she can hear us in the lounge. Unfortunately, there aren't enough of us to do that". The staff member went to see the person and said, "Ah, you want company. I am busy at the moment, I will come back". Other staff spoke to us about the concern they had that this person became anxious and they did not have time to spend with them.

A second person was described as requiring two staff to support with personal care and to go to the toilet during the day. We asked the registered manager how they managed this for the person overnight. We were told the person had their continence pad changed by two staff at 9.30pm and then again at 6.30 -7.30am when another member of the day staff started their day shift. It was not expected they would be changed between times and therefore would not require two staff. If they did, staff could call the sleeper. Staff said they would not call the sleeper if the person needed their continence pad changed at night as they had expressed they only wanted female staff to deliver personal care. Staff felt it was important to respect this. Staff also stated the person could require their pad being changing overnight. Staff confirmed they would change the pad by themselves if it was needed. This person weighed 57.8kg (just over nine stone) in October 2016 and staff stated they knew they risked injury to the person and themselves in order to meet the person's need in the absence of a second member of staff.

This person was also a high risk of falls and pressure ulcers; they had a grade three pressure ulcer on their hip which was being treated by the District Nurse. On the 16 November 2016 the District Nurse confirmed they would have expected two members of staff to support this person at night because of their high risk of skin tears. Also, as this was the same person who had been injured by the heater, they would have expected two staff to have been moving the person very carefully to protect the site of the injury. Their night time care plan (reviewed 11 October 2016) stated they should be moved every two hours. A slide sheet was in use and a bed lever in place "to enable me to turn with the assistance of staff", but this had not been reviewed since the current injury.

During the daytime on the first day of the inspection, there were two staff delivering care to everyone. There was also one senior carer, who was completing medicine round and other tasks than personal care, deputy manager and registered manager on site. We observed staff were rarely in the conservatory or lounge and there was no means for people who relied on staff support to mobilise to call staff for support or help. There was one call bell on the wall. It was not possible for us to speak to staff on the first day as we would be increasing the risk to people. We requested the registered manager and provider look at their staffing so we would be able to speak to staff on the second day. A third member of staff was deployed so we could speak to staff.

Staff raised concerns with us about the staffing levels in the day and night time. All staff felt they needed to be task focused. For example, one staff member said they tried to spend as much time with people when carrying out personal care in the morning as they could, but had to try and get everyone up in a reasonable time frame. Another staff member said they were worried at night if the staff member or person became ill as "none of the residents can call for help. You have to leave someone who is sick, unhappy or distressed". Another staff member said, "Staff are putting people and their selves at risk doing things on their own".

Not having sufficient numbers of staff deployed to meet people's care and treatment needs is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We requested the registered manager and provider took immediate action to provide safe staffing levels at night. We also asked them to review the day time staffing levels. They immediately arranged for an agency

staff member to provide a second member of staff during the night. When we returned on the 21 November 2016 we were told there was three care staff in the day and two at night and this had been maintained since the 16 November 2016. The provider and registered manager did not commit to the increased staff numbers. The registered manager stated, "No, there is no commitment to maintain this" and, they would be waiting "until the [inspection] report is out". They added they would be using a range of audits to gauge the number of staff required. A director of the company stated, "Staffing is subjective".

All the staff we spoke with on the second day of the inspection commented positively on having the extra staff employed. Comments we received included, "I could give the residents more personal care and spend time with them being more person centred" and, "Today we had extra staff and it was nice".

People were not fully protected from the risk of developing pressure sores. On the first day of the inspection, every person who had an air mattress in place had them set to a weight of 100kg (15.7 stone). The mattresses were in place for people identified as being at high risk of pressure sores and were recommended as a means to prevent this happening. We spoke with the registered manager and asked why the mattresses were not being set in line with people's weights as expected. They told us the District Nurses had not told them how to set them. We asked them to review people's weights and set the mattresses to the correct weight for the person to prevent the risk of skin breakdown. We also found they had failed to regularly check the air mattresses were working. After the inspection the registered manager told us they had put systems in place to address these concerns.

People were not fully protected from other risks to their health and safety. People had risk assessments in place in line with the risk of falling, skin breakdown, malnutrition and being moved by staff. These were updated at monthly intervals and linked to their care plans. However, there were no risk assessments in place in respect of people's individual needs where they were at an increased risk. For example, there were no risk assessments in place for people at risk of choking, who were diabetic and/or were prescribed medicines that were a higher risk. We discussed this issue with the registered manager who began to look for ways to ensure people's individual risks were reviewed.

People's accidents were collated and reviewed for the individual but there was no whole home assessment of these falls and accidents to see if learning could take place. The registered manager stated they would review this.

Staff were trained in how to meet people's needs in the event of a fire; a contingency plan was in place and a place of safety in the community identified. People had personal emergency evacuation plans (PEEPs) in place. We found the service did not have evacuation equipment in place and a fire risk assessment completed in September 2015 identified some remedial action needed to be carried out. For example, the service need to ensure doors had the recommended burn time. One of the directors told us all three homes they managed had needed work and the Old Vicarage was to have this work completed soon. Work had been carried out at the other two homes run by the same directors. We passed the details onto the Fire Service who advised they will be completing their own check as they had previously advised the service about the doors in 2010.

Not having systems in place to keep people safe is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the service informed us that the fire service had visited and alerted them to the same concerns about fire doors. The home confirmed that it had carried out the remedial actions suggested in relation to these doors.

Prior to the inspection we were told there had been a number of medicines errors. We were told staff who had been found to have made errors were still administering medicines without further training or checking of their competency.

Medicines were administered by staff trained to complete this task. All medicines were stored safely and securely. People had their medicines as prescribed and records of this were kept in their Medicine Administration Record (MAR). There was a process in place to ensure staff knew how to apply and record the use of people's prescribed creams. Competency assessments of staff were taking place. The audit of medicines administration was not ensuring stock of medicines was accurate and there was no audit of medicines that were subject to higher levels of control. Practice issues had been picked up and the registered manager began looking at addressing the other issues mentioned. Subsequent to the inspection, the home informed us that they had implemented a full medicines audit designed to ensure that stock levels were accurate.

One person said, "Staff are very professional about pills. When I go out for the day they give them to my daughter. They know what they're doing".

Staff were administering a person's insulin and had been trained and checked as competent by the district nurse to do this. One person was taking Digoxin and was not having their pulse checked before administration in line with good practice. The registered manager contacted the person's GP to ensure they had the right advice and put a risk assessment and policy in place on how this person's medicine was to be managed going forward. Staff confirmed they had been updated.

We recommend the registered provider and registered manager ensure the management of medicines is in line with the current guidance.

People were not fully protected from the risks associated with hygiene and infection control. The service was clean and people told us they were happy their rooms were kept clean. Remedial work had taken place since the last inspection to address the concerns about the maintenance of the service that were placing people at risk. Prior to the inspection we were told that a member of the kitchen staff was also handling contaminated clinical waste with a risk of cross contamination. We spoke with the registered manager about this who confirmed this staff member was taking the contaminated waste out at the end of their shift. They did not wear their kitchen uniform and had different gloves and aprons to wear for this. We spoke with the registered manager about there being no liquid hand soap, paper towels and bins with a lid in people's ensuite to ensure staff and visitors were washing their hands. The only soap available was blocks of soap people used for their personal care. Blocks of soap are for the personal use of the person as they are a risk of cross contamination. The registered manager advised they would look into putting this right.

An audit of infection control was taking place and one staff member had the role of champion to monitor infection control practices. We did however raise a concern on the first day that staff were using gloves around the service without removing them or demonstrating they were washing their hands; for example in the kitchen and in the corridors and when administering medicines. This practice had been corrected by the second day.

New staff recruited throughout 2016 had not received infection control information as part of their induction. They were given a copy of the service's infection control policy. However, they had yet to complete a standalone course. The provider advised staff are going to complete this as part of the Care Certificate. Staff were also reminded of their infection control responsibilities during staff meetings. The registered manager advised all training was under review.

We recommend the registered provider and registered manager ensure they are following the current guidance for care homes in respect of infection control practices.

People using the service said they felt safe. Comments included, "If I need help, I press my buzzer and staff come", "They treat us very well here, I do feel safe" and, "I feel very safe here". One visitor said, "I feel my relative is safe here".

Staff were knowledgeable about safeguarding people and keeping them safe from abuse. They stated they felt any issues around risk to people in respect of abuse would be acted on and the registered manager would speak to the local authority.

Staff were recruited safely and only started work when the necessary checks were in place. They completed a probationary period. The registered manager reviewed staff members at the end of their probationary period to check they remained suitable for the role.

Requires Improvement

Is the service effective?

Our findings

The provider and registered manager were unable to provide evidence to show that all staff had received adequate training because there were significant gaps in training records. This was particularly for staff who started to work for the service throughout 2016, the registered provider and staff responsible for maintenance. Staff who started in 2016 had not had safeguarding vulnerable adults training, for example. The registered provider was not recorded as having completed manual handling, food hygiene and infection control training despite carrying out tasks requiring this training.

New staff received induction training at the start of their employment to ensure they had the basic skills to meet people's needs effectively. A newer member of staff told us they had "shadowed experienced staff for two to three weeks" when they first started. They then had a review with the registered manager to ensure both were happy for them to work on their own. They were also undertaking the Care Certificate. The Care Certificate is a national initiative to train staff who are new to care to the same recommended level. They said they had completed training in manual handling, dementia care, oral care, pressure care and first aid since they started in September 2016. Other staff confirmed they had received regular training in the provider's mandatory topics.

Staff had received training on some health needs relevant to the people living in the home, but we identified further topics that had not been covered. For example, staff had received training to help them understand the needs of people living with dementia but they had not received training on Parkinson's disease.

Supervision was taking place when there was a concern about practice. There was no record of ongoing appraisals. The registered manager explained that staffing issues had affected their ability to do this but was aiming to ensure supervisions were completed more regularly in future.

We spoke with the registered manager about the gaps in the training records. They assured us the provider's training manager would ensure staff received training on all essential topics in the near future. They also stated there may have been an issue in the recoding of training and said action would be taken to make sure the training records were accurate.

At the last inspection we found assessments had not been carried out to identify people's capacity to consent to their care and treatment. We also found the service had failed to ensure the correct legal agreements had been obtained where people were being deprived of their liberty.

We checked again on this inspection 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.

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 application procedures for this in care homes is called the Deprivation of Liberty Safeguards (DoLS).

We found the service was working within the principles of the Mental Capacity Act 2005 (MCA) and conditions on authorisations to deprive any person of their liberty were being met. The recording of people's capacity and their ability to consent to their care and treatment was clearer. Assessments identified the different aspects of people's lives where it was thought they could not consent and staff supported people to use their right to consent in areas where they could still act. For example, one person's inability to consent to their care and treatment was made alongside instructions to staff on the person's ability to say what clothes they wanted to wear. Staff were told the best way to achieve this for the person. DoLS applications had been made to the local authority in respect of any person who needed them. However, where staff were acting in people's best interests this had not been recorded as clearly. The records did not show who had been part of the decision making on the person's behalf. We spoke with the registered manager and they stated they would review how they recorded this information

Staff had received training in MCA and DoLS since the last inspection and described how people's needs should be met if they lacked capacity or had a DoLS assessment requested.

When staff were present in the communal areas, they were observed offering people the opportunity to consent and agree to the care on offer. For example, when going to the toilet before lunch. Staff were clear that it was important to communicate with people and seek their consent, regardless of how busy or rushed they were.

People's needs to have enough to eat and drink were met. People said they had enough to eat and drink. People had fresh jugs of water or juice in their rooms or available through the day. Drinks of tea or coffee were not just offered at set times; people were offered them or could ask for them at other times. One person said, "They come round with a jug of fresh water every day" and another person said, "Staff come round with cups of tea and biscuits".

People were supported and encouraged to eat and drink as needed. Where there was a concern about someone losing weight or being off their food, help and support was requested from relevant health specialists. Advice was followed and food supplements were given as prescribed. People's needs were monitored and staff were recording what people had eaten and drank on most occasions but not all. However, the recording was sometimes untidy and not always reviewed to make sure people were eating and drinking enough. We discussed this with the registered manager who stated they would review this with staff.

Lunch and tea times were sociable occasions. People sat at communal tables, and people were talking to each other as they ate. Some people could have clothing protectors if they wanted. One person brought theirs to the dining room and staff said "Would you like to use your apron?" and, "I'm going to put your apron on". Tables were laid nicely, with flowers and condiments and napkins. A member of staff went around the room with a bottle of ketchup which they offered to people saying, "Do you want a puddle of sauce or all over?" Although said in a kindly voice, people could do this for themselves to promote independence. People were offered a choice of drinks to have with their meals. One person told us, "We get offered wine on Sundays and I can have a glass of bitter if I ask for it".

Kitchen staff were knowledgeable about people's needs and were flexible in offering people what they wanted and liked to eat. People had chosen their food the day before and although many people could not

remember what they had ordered, staff reminded them gently and people could change their mind. At lunch, there was a choice of two main courses available. The food was hot and there were good sized portions. People gave positive comments about the food. One person said they enjoyed their lunch "very much" and another said, "Very nice, warm and plenty of it".

People could access healthcare as required. Records detailed and people confirmed that they could see their GP as needed. A range of health professionals such a physiotherapists, dieticians and occupational health therapists had been involved in people's health and supporting staff meet their various needs. The district nurses stated they were happy (apart from the situation referred to in the safe domain) that the staff referred people to them in a timely fashion and followed advice. People also had regular appointments with an optician, chiropodist and dentist.

Requires Improvement

Is the service caring?

Our findings

People were having their end of life needs met in a caring way. However, people were not having their end of life wishes and choices recorded. One person with significant health needs did not have a care plan in place which told staff how they wanted to be cared for at the end of their life and whether they wanted anyone special with them at this time. Staff were recording when they were supporting the person to be in bed or in their chair in the day time. Mouth swabs were in their room and the district nurse was visiting daily to monitor the person. The GP had visited and reviewed their medicines; "as needed medicines" were available to support them to be pain free. The person told us they were happy with the staff support and said, "They are very good" and, "Yes, staff come" to see them often and made sure they were comfortable. We spoke with the registered manager and highlighted a lack of care plan to bring all the above details together which would then detail for staff how to support the person as they would want. A brief care plan was drawn up in response to this.

We asked the registered manager how they made sure staff knew how to manage, respect and follow people's choices and wishes for their end of life care as their needs changed. Also, how were people's preferences and choices for their end of life care clearly recorded, communicated, kept under review and acted on. They advised us staff received a regular update in the handover sessions and there was close communication with the district nurses. They would however, look at improving the gathering of information and recording of people's advance decisions and changing the records in line with people's changing needs.

Staff were observed being respectful in the way they spoke with people and spoke kindly and patiently to people when this was needed. People were spoken to with politeness and staff told people what they were doing before they did it. For example, we heard staff say in a kindly tone, "I'm going to take you to lunch now" and, "Would you like some lunch?" One person was supported to have their lunch later as they were tired and wanted to sleep in the chair and did not feel like eating their lunch at the same time as everyone else. Staff kept checking on them and they had their lunch in their room in the afternoon in line with their choice.

People told us staff always made sure their dignity and privacy was protected during their receiving personal care. We observed on our first day at the service, staff called people by their chosen names, but only spoke to people when asking them a direct question. We did not see any staff sitting or just chatting to people on the first day; on the second and third day this was more evident. For example, on the second day a staff member was doing a person's nails and another was then sitting and looking through the care plan with another person a little later on. Staff said this was possible with the extra staff member.

One staff member said they tried "to be attentive and take time to listen" and, "sometimes have time to chat especially those in their room; they're alone". Another staff member said, "Dignity issues are really important; where management are told about people's needs they are really good. They really care" adding, "Most staff have a good attitude" but as they are so tasked focused "Residents are forgotten in the wind". A third staff member said, "Staff communicate well with people and are doing their best; we wish we could

have time to chat".

A new member of staff said, "The staff are very caring to people and good at their job roles; two staff in particular are very good and attentive to people". They added they felt they were able to learn a positive way of working with people from the staff.

People spoke positively about the staff. Comments included "Staff are happy, but not false. They are naturally happy. They laugh a lot", "New staff are always introduced to us" and, "I can't complain about living here. Friendly staff, good food, comfortable rooms; what else can I ask for". Other comments included, "The staff are very nice, they're all very kind", "I am happy and content here" and, "The staff are kind".

Relatives said "We're really happy with the service. The staff are so kind here, they really can't do enough" and, "My relative loves this place, she's been in hospital recently and got very confused there. She is much better here".

People felt in general control of their care. People had allocated key workers who would follow up on any needs. One person said "I get a paper delivered and I like to do the puzzles".

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we raised a concern that people's records were not always completed accurately by staff. Where staff were checking on needs, these were sometimes incomplete. Care plans did not reflect current needs.

On this inspection, we found people were assessed when they moved into the home. Care plans had been drawn up and agreed with people to ensure staff knew how to meet their general needs. People's care plans in respect of their personal care, for example were personalised expressing how they wanted this care given by staff. However, some health needs such as dementia, heart problems and diabetes had not been explained clearly. This meant staff had not been given sufficient information to ensure they understood how these conditions affected the person and what staff could do to support them. The care plans were poorly organised which meant information was not always easy to find. We fed this back to the registered manager who stated they would look at ensuring people's care plans were clearer when it came to people's individual, specific needs.

Some people knew about their care plan and said they had been involved in writing it. One person said "Yes, I've read my care plan and I see what goes into it" while another person said, "I don't know". We were told by the registered manager that people had a key worker allocated who had responsibility for reviewing people's needs with them. On the second day a member of staff sat with a person to go through aspects of their care plan. Two relatives told us following the inspection they had been kept up to date in respect of their relative's care.

People could not be fully confident that any changes in their needs would be met safely. Staff said they did not have time to read the care plans and relied on the staff handover sessions to update them on people's current needs. However, we were also told by staff who started later in the day or were returning from holiday they were not updated on people's needs. We spoke with the registered manager about this to check what their expectation was. We were told there was a "handover book" but not all staff were reading this. The registered manager told us they would review handover to ensure all staff were kept up to date.

People's social needs were not always met. Activities were provided for people to take part in but this depended on the availability of staff. A recent resident's meeting had requested more one to one time with staff. Staff told us they were restricted by time in meeting this request. An activity plan was provided but we did not see this followed. On the first day, a staff member came into the lounge and said, "I'm going to do a quiz; does anybody want to join in?" On the second day music therapy was timetabled but did not take place and there was no reason given. Another staff member told us, "There is not a lot going on in respect of activities; nail painting, bingo, games sometimes by carers. Organised activities are rarer." Adding, "People here are bored to tears". Staff told us they tried to speak to people about what they liked when doing other tasks. For example, one person liked to keep up with the news and the staff would pick this up with them when they saw them.

People's faith needs were met as required. People could come and go into the garden as they liked.

We recommend the registered manager identifies individual people's social needs to ensure these are met. People knew how to make a complaint. One person said, "I would complain to the boss, but I've never needed to" and, "I know how to complain, it's on the back of the door. I also go to residents' meetings". A visiting relative said, "No, we've never had to complain. We're really happy".

A complaint policy was in place to support people to complain. People's complaints were taken seriously and investigated. Feedback was given to people and their relatives to check they were happy with the outcome. Staff said they would listen to any person's complaints or concern and pass this onto the registered manager or deputy manager for them to follow up.

Inadequate

Is the service well-led?

Our findings

There was a registered manager employed to manage the service. They were supported by a deputy manager.

The Old Vicarage was registered with CQC to be run by Mr William Dunnett Jackson. However, when we spoke with Mr Jackson on inspection, we were told that a limited company called Old Vicarage (Churchill) Ltd was responsible for the management of the service. This company had been registered with Companies House on the 24 January 2001.

Our records show that Mr Jackson confirmed with us that he was the provider on the 18 June 2010. In May 2015, we advised Mr Jackson that his details did not match that of Companies House. There is no evidence that Mr Jackson acted on this information and ensured who managed The Old Vicarage was correctly registered with the Commission.

Failure to give notice of changes to the Commission is a breach of Regulation 15 of the Care Quality Commission (Registration) Regulations 2009 (Part 4).

Mr Jackson advised he would seek to ensure the service was registered correctly with CQC. We have now received Mr Jackson's application.

CQC had not received the required notifications of serious injury. Prior to the inspection our records showed the provider had failed to notify us of any serious incidents, injuries or accidents between 2014 and 2016. During the inspection we saw records of a number of incidents that had occurred in 2016 including a burn, a grade three pressure ulcer, a fractured finger, a fractured hip, a head injury, and a person had been transferred to hospital after a fall. Also a person had suffered skin tears which on at least one occasion had required dressings to be used and treatment from the district nurse. This meant the provider had failed to meet their statutory requirements to inform the relevant authorities of notifiable incidents in a timely way.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (Part 4).

We requested the registered manager reviewed all accidents to check whether they should have told us about them. Following the inspection we received retrospective notifications of the burn, grade three pressure sore, fractured hip and fractured finger. We reminded the registered manager on inspection they were required to tell the local authority of any grade three and above pressure sores. We also reminded them to ensure they tell us about any safeguarding investigations undertaken by the local authority.

We found on this inspection systems were not in place to make sure there were enough staff to meet people's needs safely. We also found the registered manager and provider had not met their obligations in respect of the safety and welfare of people living at the service. Systems and processes had been ineffective in monitoring the risk to people of contact with heated surfaces, the risk of scalding and the risk of falling from a height. As a result one person had experienced significant harm and others had been placed at risk.

Audits were taking place in respect of care plans and infection control. Medicines, except those which required higher levels of control, were being audited. However, a number of audits were not in place such as call bell response times and falls. Falls or accident records showed a high number of falls or accidents were taking place. In 2016 it was recorded (to date) that 102 accidents had taken place These incidents were not being reviewed against staffing or environmental risks, for example, to keep people safe from further harm. This meant the provider had failed to put in place systems to effectively assess the quality and safety of the service, and to make improvements where necessary.

We found the registered manager had been supporting care prior to this inspection. When we requested some records we were told on several occasions they were somewhere in the registered manager's office (for example, staff references and contracts for repairs to equipment) or the staff member concerned had not had the time to write up the piece of information (for example, infection control audit and checks). These were provided following the inspection. When we spoke with the registered manager, they confirmed they were not as organised and up to date in their record keeping as they would have hoped for. Following the inspection, the provider explained that it was correct that the registered manager was supporting care; this was done because the home was trying to recruit staff and they felt it was better to ask the registered manager to help out rather than use agency staff.

Accurate records were not always kept. Records did not record all the risks people faced. Records also did not detail when staff were acting in people's best interests or showed who had been part of the decision making on the person's behalf when they could not do this for themselves. People's end of life choices were not clearly recorded. The records of staff training were thought by the registered manager to be incomplete.

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

We did not find there was an emphasis on transparency or an open culture. At the start of the inspection we had asked the registered manager to tell us what everyone's needs were and raised an issue with the registered manager about the heaters. This was because we had seen one at the top of a landing which was hot to the touch and not covered. We asked the registered manager if this was supposed to be a cool-wall heater as it was not covered. We were not told about the injury the person had experienced from the heater on either of these opportunities. We only found out about this from raising a query about this person's care with the District Nurse due to the staffing at night.

Staff told us they felt they could approach the registered manager and could suggest changes in how the service was run but did not feel they were heard. Staff told us they had spoken about the staffing to the registered manager and in staff meetings but they had not been listened to. Minutes of two staff meetings held in 2016 demonstrated staff had attempted to raise issues about staffing levels. Staff told us they concentrated on working as a team and trying to meet people's needs. All the staff said they did and would go without their own breaks to meet people's needs and support people.

Most people knew who the manager was and referred to them by name. One person said "I know them when I see them".

People and their family were asked their view of the service. People said they attended resident meetings "every two to three months". People said, "We discuss everything and anything at the meetings" and, "The meetings are chaired by staff". Questionnaires were sent out to be completed by people, family and professionals once a year. The feedback for the one completed last time was very positive.

The registered manager understood their obligations and requirements under the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment. Registered persons are obliged to apologise when things go wrong.

The registered manager had systems in place to ensure the equipment was safely maintained.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 Registration Regulations 2009 Notifications – notices of change Regulation 15(1)(a) The registered person had not given notice to the Commission that a person other than the registered person was managing the regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Regulation 18(1)(2)(a)(ii)(iii) The registered person had not notified us without delay of incidents of serious injury.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12(1) and (2)(a)(b)(d) Care and Treatment was not provided in a safe way for people in respect of assessing the risks to their health and safety; doing all that was reasonably practicable to mitigate any risks and by ensuring the premises were safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18(1)

Sufficient numbers of staff were not deployed to meet people's care and treatment needs.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17(1) and (2)(b) System and processes were not established to assess, monitor and mitigate the risks relating to the safety of people residing at the service.

The enforcement action we took:

We imposed a positive condition on the provider's registration. This required the provider to make certain checks and report to us on a monthly basis. We will report on the provider's progress at our next inspection.