Central England Healthcare (Stoke) Limited

The Old Vicarage Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
The Old Vicarage Nursing Home is a care home providing personal and nursing care for up to 45 people aged 65 and over. 39 people were living in the service, although two of those people were in hospital at the time of our inspection. The service can support up to 45 people across two floors, part of the top floor was dedicated to people living with dementia.

People's experience of using this service and what we found
People felt safe living in the home, however they were not consistently supported by a caring staff team. We saw people did not always have their choices respected. A number people were unable to reach their call bells when they were in their rooms. Staff were tasked focused.

Risk assessments were in place for people, however, audit documents did not always highlight people's wound care needs. Medicines were effectively managed and administered safely and protocols were in place.

People had care plans in place which were reviewed and updated which included their support needs. These plans provided staff with information to supporting people living in the home which detailed people's preferences. However, people's end of life wishes was not consistently sourced or recorded in people's plans.

Accidents and incidents were monitored to identify trends and address any concerns. Systems were in place to manage infection control, although nurses were observed not wearing gloves when distributing medication, meaning there could be a risk of cross contamination.

People were not always supported to have choice and control of their lives. Although staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the home supported this practice.

People did not always have the choice to choose where they wanted to spend their time and had access to the communal areas and a garden area. However, there were a large number of people spending time in their rooms.

Staff had good relationships with external agencies which supported people to live a healthy life, however, Staff did not always follow professional advice which impacted on people's health and wellbeing. and guidance for people. guidance was not always followed. Majority of people had their dietary needs assessed and people were seen by professionals to support their needs, although this was not always done in a timely manner.

People were encouraged to participate in activities to ensure they were not isolated, this included a weekly

trip to the community centre. Staff were able to have meaningful conversations with people as they had an understanding of people's hobbies and interests.
People that were at the end of life were being supported appropriately. However, people that were not nearing end of life did not always have their advanced wishes considered or recorded.

The provider had a complaints process in place however, people and relatives were unaware of the process.

The provider was aware of their responsibilities and had systems in place to monitor the home and to identify where improvements could be made, however, these were not always effective in identifying improvements to be made.

Statutory notifications had been completed to inform us of events and incidents, this helped us to monitor the action the provider had taken.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Good (published 05 January 2017)

Why we inspected
This was a planned inspection based on the previous rating.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

The Old Vicarage Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection team consisted of 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.

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

During the inspection
We spoke with 11 people who used the service and seven relatives about their experience of the care provided. We spoke with four members of care staff as well as the registered manager, deputy manager/nurse, and the chef. We also spoke with five visiting professionals. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included three people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. We looked at a variety of records relating to the management of the service, such as governance arrangements and policies and procedures.

After the inspection
We spoke to the local authority following the inspection as they had carried out a visit to the home after our inspection.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to, Requires Improvement.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

- The provider had a tool in place to calculate the number of staff required in the home to meet people's care and support needs. This tool considered people's care needs and the layout of the building.
- However, feedback from people, staff and visiting professionals was variable in relation to whether there were sufficient numbers of staff working in the home. Comments included, "It is alright here but there's just not enough of them [staff]." A relative said, "We looked at the reviews of this place and it seemed good. It sometimes seems a bit short staffed but [relative] tells me they [staff] are good to them." Another relative said, "At times they could do with more [staff] sometimes they only have three on the floor and they could really do with a fourth person." A professional said, "The main issue is when you want to find someone you can't, there does not seem to be enough staff."
- Our observations during the inspection were that the majority of people spent time in their rooms. Although the registered manager told us that people chose to spend time in their room, staff did not spend time initiating interaction with these people.
- During the inspection a number people we spoke to were unable to reach their call bells when they were in their rooms, this meant they were unable to summon assistance. We raised this with the registered manager, who addressed this concern at the time of the inspection.
- We recommend that the provider review their dependency tool and the deployment of staff to ensure that sufficient numbers of staff are deployed to provide consistently personalised care and support, and to facilitate positive interactions between people and staff.

Learning lessons when things go wrong

- All accidents and incidents were recorded and reviewed by the registered manager.
- Information was shared with staff during team meetings and memos were sent to staff highlighting areas of improvement.
- Staff were safely recruited, and appropriate checks were carried out, such as checks with the Disclosure and Barring Service (DBS). The DBS check ensures people barred from working with certain groups such as vulnerable adults would be identified.

Preventing and controlling infection

- Whilst care staff were knowledgeable in how to prevent the risk of infection and followed the correct procedures we observed nurses were not wearing gloves when administering medicines. This meant people were at risk of cross contamination and nurses were at risk of absorbing medicines through their skin, when

it was not prescribed for them.
● The home was clean and odour free.
● The service had received a four-star rating from the Food Standards Agency (FSA) meaning the service had appropriate food hygiene.

Systems and processes to safeguard people from the risk of abuse
● People told us they felt safe living in the home. One relative said, "Yes I think [relative] is safe here, the staff seem competent enough, everything that needs to be done is being done and everyone knows what they are doing."
● Staff had completed training in safeguarding people from harm and abuse. Staff we spoke to stated they would report their concerns to the nurses who would then go through the relevant forms. Audits were completed which identified safeguarding alerts and highlighted actions to be taken. For example, to discuss lessons learnt with staff team and to ensure conclusions are recorded.

Assessing risk, safety monitoring and management
● People's care plans contained risk assessments which supported staff to promote people's safety.
● Staff we spoke with understood people's risks and how to support them safely. One staff member said, "Everything we need to know is found on the yellow cards in front of the folders, these are kept in every residents rooms, or if they are out in the lounge they will be in a draw or a cupboard."
● We observed people being supported safely when using equipment, such as hoists. Staff reassured people during the process, and people appeared relaxed.
● Emergency plans were in place to ensure people were supported in the event of an emergency including how to get people out of the building safely in the event of a fire.
● A range of safety checks were carried out on the environment, including fire a risk assessment which had detailed actions.

Using medicines safely
● Clear guidelines, procedures and protocols were in place to ensure people received their medicines as prescribed. One person said, "The [staff] look after me well, they deal with my tablets."
● Trained nurses administered medication and their competency was observed to ensure they did this safely.
● People told us they received their medication as prescribed and medications reviews were carried out.
● Medication was stored securely, and audits were carried out.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to, Requires Improvement.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People did not always have their care delivered in line with their needs and choices. People receiving one to one care had this carried out by agency staff. We found there was no consistency in the care being provided as they had very little knowledge about why they were supporting people on a one to one basis. This meant for people on a one to one support package there was no understanding of care needs and how best to support them.
- We spoke with agency workers during the inspection and asked if they knew what the support needs were in relation to the people they were supporting. One agency worker said, "No, I have no idea."
- People had assessments completed before moving into the home to ensure their needs could be met. However, these assessments were not always effective at ensuring people received timely support from professionals for their needs. Some relatives we spoke to shared concerns that care staff were unaware of their relative's needs.
- For example, we saw one person's pressure sore had not been documented on the 'weekly wound monitoring form' and they did not have the correct resources in place such as; an airflow mattress to support them. This meant that the systems in place were not effective in assessing people's needs.
- We brought this to the attention of the registered manager and operations manager as they were not following their own procedures in assessing or changing people's wound dressing within three days. The registered manager and operations manager revisited their systems by changing their current way of working to reviewing care 72 hours after admission inclusive of weekends.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- People had access to a wide range of health professionals, which was documented in care plans. However, staff did not always act on feedback or ensure information was shared with professionals effectively.
- Staff did not always follow professional's advice. One professional said, "We asked someone to be put someone back to bed after two hours due to their fatigue, they were still sat there four hours later." We addressed this with the registered manager who stated that professionals had been requested to inform senior staff as care staff can become distracted and can forget to hand this over. The registered manager identified this was not best practice as the information should be passed on and noted.
- We spoke to a number of professionals and received comments which included; "The staff here are really

helpful but the quality of the handovers are not great, for example, informing us that a new resident has come into the home or if residents have a urinary tract infection (UTI)" and "The registered manager has a lot of good points and will act on things when you raise them."

Supporting people to eat and drink enough to maintain a balanced diet
● Records detailed people's nutrition and hydration needs, including people's specific dietary needs were catered for.
● Staff were knowledgeable in relation to people's needs and preferences.
● Comments received from people to their thoughts of the food were, "The food is varied here, it is okay", and "The meals are alright." A relative said, "[Relative] seems to get a lot of bread, toast, sandwiches for tea, there is too much pastry stuff."
● The home had three dining rooms. The two dining rooms on the first floor were bright and airy, however, the dining room on the ground floor was much smaller and dark.
● We observed little interaction between staff and people during lunch time which impacted on the overall dining experience for people. Staff were busy going in and out of the dining rooms with plates of food in order to serve other residents in their rooms.
● The kitchen staff had information they needed about people's dietary needs and preferences on display in the kitchen and would ensure they spent time with people getting to know their needs.
● We saw that advice was sought from health professionals such as Speech and Language Therapists (SALT) to ensure people were supported effectively to reduce risks, such as choking.

Ensuring consent to care and treatment in line with law and guidance
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 to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
● People's capacity to make decisions had been considered and mental capacity assessments had been completed for all aspects of the people's care. This was documented in people's care plans.

Staff support: induction, training, skills and experience
● People were supported by staff who had received training relevant to their roles.
● Staff received an induction into the home when they commenced employment. The induction included competency checks after receiving training to ensure staff were competent before they commenced working with people.

Adapting service, design, decoration to meet people's needs
● The home was adapted based on the needs of the people living there. For example, some handrails had

been removed to accommodate some wheelchairs. These could be returned if a person required them.
● The home had recently been re-decorated. The communal lounges were bright and airy. There was a quiet room for people to use and people had access to a garden area.
● The home had recently implemented a memory unit which supported people with memory loss.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to, Requires Improvement.

This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care

- People did not consistently have their wishes respected. For example, one person told us they did not always get to the dining room for breakfast at their desired time. They required support from staff to move to the dining area and this was not provided in a timely way. They said, "It's too late, I'm always the last to be wheeled in, I'm not on time." They went onto to say," I have raised this at the residents meeting they [staff] wrote it down but I don't know if anything will happen."
- We saw in people's care plans their preferences in regard to what time they liked to be out of bed, these wishes were not consistently fulfilled, and we saw people remained in bed after their desired time of getting up.
- People were able to express their views through the resident's meetings and were consulted through surveys.

Ensuring people are well treated and supported; respecting equality and diversity

- Staff were task focussed and at times rushed, this impacted upon their ability to have consistently positive engagement with people.
- We observed that the quality of interaction between people and staff was variable. During the inspection we observed examples of positive interaction. For example, one staff member was seen speaking to a resident about 'old times' and what they used to like to do. However, we also observed occasions when people's wishes were not followed and the interaction between people and staff was rushed. For example during our lunch time observations, staff did not engage in meaningful conversations with people who were being supported.
- People and relatives told us they were generally happy in the home. Comments we received from relatives were, "There is always a jug of water in [relatives] room and they [staff] are very good at bringing round cups of tea, [relative] likes their cups of tea" and "I love it here and so does my [relative], the staff are fantastic, they have been marvellous. They have looked after me as well as my [relative] to be honest."
- People's assessments addressed their equality and diversity needs. The registered manager said, "One person may like to have alone time and we allow them to go to their room and have that alone time." One staff member said, "I treat everyone as individuals, respecting their needs, preferences and religion."
- The Old Vicarage Nursing home had a scheme called 'GEMs' this involved staff 'going the extra mile' for people and assisting them with something which is important to them to improve their day. For example, one person has a passion for steam trains, and staff are trying to source a day out for them involving steam trains.

Respecting and promoting people's privacy, dignity and independence

● Staff respected people's privacy, dignity and independence. Throughout the day we observed staff supported people whilst maintaining their dignity. For example, ensuring ladies legs were covered when being hoisted, knocking on doors before entering people's rooms and hanging signs on the doors stating personal care was in progress.

● Staff understood the importance of promoting people's independence. One staff member said, "I try and push them [people] to do as much as they can for themselves."

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same, 'Good'.

This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- We saw in people's care plans their preferences in regard to what time they liked to be out of bed, these wishes were not consistently fulfilled, and we saw people remained in bed after their desired time of getting up.
- People were able to express their views through the resident's meetings and were consulted through surveys.
- People had their own care plan in place. We saw that these recorded information about people's likes and dislikes and preferences for their care and support. There was clear information in parts of the care plans. For example, one person's care plan recorded clearly what time they preferred to get out of bed. However, this information was not always followed by care staff; we saw this person was still in bed some hours after their preferred time.
- People's care plans detailed people's preferences which included 'getting to know me' which described what employment people previously had and what they liked to do.
- People had daily support plans located in their bedrooms, these detailed people's needs and preferences, including if they preferred receiving support form a male or female staff member.

Improving care quality in response to complaints or concerns

- The complaints procedure was available to people and relatives. There was a complaints procedure within the information packs located in people's rooms and was also displayed in the entrance hall to the home. Whilst there was a complaints procedure in place, we received a mixed response with regards to people knowing how to complain. Relatives said, "I do not know the hierarchy of the place, but I would probably go to the admin office and I would have a look at the gallery pictures to see who the manager is", and "If I had any complaints about my [relative] I would mention it to the nurse." One person said, "The place is fine I have no complaints."
- During the inspection one person and one relative complained to us which we addressed with the registered manager. The registered managers responded to these complaints and resolved the issues raised. We followed up on one of the complaints on the second day of the inspection and the person told us they were very happy with the outcome. However, if we had not been informed about these concerns, they may have been missed.

End of life care and support

- The home was supporting people at the end of their life at the time of the inspection. People's care plans

did not consider their advance wishes or preferences. For example, one person's care plan stated 'Co-op' funeral plan in place. This did not demonstrate their wishes in planning for their end of life wishes. This meant staff had no understanding to what people's preferences were should they be nearing the end of life.
● Despite this, people at the end of their life were getting a dignified and pain free death.
● The home had an initiative supporting people at the end of life, where a purple bow was placed on their bedroom doors. This raised awareness to staff, the registered manager said, "Where people have purple bows staff know we need to keep quiet and respect this by not having conversation outside of their doors and housekeeping not going in to hoover."

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● We observed some positive interaction between staff and people and saw one staff member in the communal lounge encouraging a person to reminisce. However, during the inspection we observed people that spent large parts of their time in their own rooms lacked any form of social interaction. The registered manager informed us this was down to people's preference to spend time in their rooms.
● The home had a weekly activity timetable and people told us they enjoyed some of the activities. However, outside of these formal activities there was a lack of support for people to follow their interests. One person said, "I go across to the community centre to play bingo on Wednesday afternoons." A relative said, "My [relative] likes to join in some activities, play your cards right is their favourite. They [staff] always come and ask if [relative] wants to join in."
● The home had an initiative called 'butterfly moments'. This was set up following consultation with residents. People who had a butterfly placed on their bedroom doors was a sign indicating they liked to have visitors. On the back of their bedrooms doors there was a notice stating what topics the residents like to discuss. The initiative supported people from becoming socially isolated. The home had won an award for this initiative for most innovative improvement.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● The home had a 'communications corner' this was located on the first floor in the corridor. The information gave an explanation in how good communication supports people. There was an array of pictorial cards available and laminated sheets for people to write on should they need them.
● The home supported people where English was not their first language. One staff member said, "We had a resident here who first language was not English, and we had a computer that translated English into their language and vice versa and family came in supported communication too."
● The registered manager told us if a person needed print in larger formats this could be provided.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to, Requires Improvement.

This meant the service management and leadership was inconsistent. Quality monitoring did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Systems were not always effective at identifying improvements that were needed. A range of audits and analysis tools were used by the management team to monitor the quality of the service. For example, analysis of medication, care planning, wound care and people's feedback.
- However, we identified different areas where these quality monitoring systems did not identify where improvements were required. This included, the quality of the dining experience, people's end of life preferences, staff deployment and why people did not always have access to the call bells.
- The registered manager was proactive in being part of the team and would regularly be involved in the nursing aspect of care which was delivered.
- The registered manager understood their legal requirement for notifying Care Quality Commission of deaths, incidents and injuries that occurred of affected people using the service. This was important because it meant we were kept informed and we could check whether the appropriate action had been taken in response to these events.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The registered manager valued the staff team. The registered manager said, "We acknowledge the staff by a simple thank you. During the Christmas period we celebrate the 25 days of Christmas and we can reward staff with financial incentives" and, "We recognise the potential in people and they could go into different roles, which is development, progression for them."
- Staff felt they were supported by the registered manager and told us they were approachable. Comments from staff members included, "There are no problems we have a lovely working relationship" and "The registered manager is very approachable, and there is good communication."
- The registered manager told us they felt supported by the provider and valued in their role.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The registered manager had informed professionals such as the local authority safeguarding team when concerns had been raised. The registered manager said, "If anyone raises a complaint straight away I will verbally apologise to that person and we will share our findings with the complainant." This was in

accordance with the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent, and it sets out specific guidelines' providers must follow if things go wrong with care and treatment.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People, relatives and staff were engaged in the service. There were resident, relatives and staff meetings where they were encouraged to share their views. Suggestions were considered, and changes took place.

● Staff told us how they were consulted with surveys, where they could make suggestions to improve the service.

● The home had links with the local community. For example, religious leaders would visit the home.

Continuous learning and improving care

● When the registered manager identified areas of improvement they did change systems which benefitted people's experience of the home.

● Daily handovers took place which ensured staff were up to date with people's needs. One staff member said, "Yes we have handovers, but when you have been off, say four days in a row and there has been a new resident in, perhaps they could be included in the handover for a few days, so when staff return from leave they are never missed." We raised this with the registered manager at the time, and they stated they would look into how this could be improved.

● The home carried out annual residents' surveys, allowing people and their relatives the opportunity to feedback about their care and make suggestions. The information gathered from these was reviewed and actions taken.

● Concerns raised during the inspection were acted upon. A memo went to out to nurses and staff with regards to; clinical photography, equipment for people on admission and recording all wounds on handover documentation.

● Staff received regular supervision and had competency assessments where their practice was observed.

Working in partnership with others

● The home worked with health and social care professionals and staff described a good working relationship with external professionals.