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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 30 March 2016 and was unannounced. At our previous inspection in January 2016 we had serious concerns for people's welfare as the service was not safe, effective, responsive, caring or well led. We had judged the service as inadequate and placed it into special measures. At this inspection we found that some improvements had been made although further improvements were required. There were still five breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have taken the service out of special measures however we will be returning to check for further improvements in the near future.

The Old Vicarage provided accommodation and nursing care to up to 45 people. At the time of this inspection 38 people were using the service.

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

Risks to people's safety were assessed, however staff did not always follow people's risk assessments to ensure they kept people safe.

The provider did not consistently follow the principles of the MCA 2005 to ensure that people consented to or were supported to consent to their care, treatment and support.

People's nutritional needs were not always met as weight loss was not noticed and acted upon.

People had access to some health care services, however some people would have benefited from referral to other health care agencies for advice and support.

People did not always receive care that met their assessed needs and reflected their preferences.

Systems were in place to monitor the quality of the service and some improvements had been made, however further improvements were required.

Medication was stored and administered safely.

People were treated with dignity and respect and their privacy was respected.

There were enough suitably skilled staff to keep people safe employed using safe recruitment procedures.

Staff felt supported and received supervision and training to support them to be effective in their roles.

Complaints were listened to and acted upon by the new manager. There was an open door policy and people felt they could approach the manager.

The new manager had made several improvements since being in post and acted quickly when issues of concern were identified with them.

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 consistently safe. Risk of harm to people was not always minimised through the effective use of care plans and risk assessments.

People were safeguarded from harm as the manager and staff knew what to do if they suspected abuse. There were sufficient staff to keep people safe and this was being kept under review. People's medicines were stored and administered safely.

Is the service effective?

Requires Improvement

The service was not consistently effective. The principles of the MCA were not always followed to ensure that people consented to or were supported to consent to their care, treatment and support. People's nutritional needs were not always met. People did not always have the support they needed from health care professionals.

Staff were supported to fulfil their role through supervision and training.

Is the service caring?

Good

The service was caring. People were treated with dignity and respect and their independence promoted. People's right to privacy was respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. People did not always receive care that met their assessed needs.

People knew how to complain and complaints were listened to and acted upon in a timely manner.

Is the service well-led?

Requires Improvement

The service was not consistently well led. Further improvements to people's care, treatment and support was required to ensure that people received care that was safe, effective and responsive to their needs.

The new manager was respected by people who used the service and the staff and had an open door policy.	

The Old Vicarage Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. This was a follow up inspection to look for improvements following our last inspection in January 2016.

This inspection took place on 1 April 2016 and was unannounced. It was undertaken by two inspectors.

We looked at information we held on the service including the previous inspection report and notifications the provider is required to send us. These are notifications about serious incidents that the provider is required to send to us by law. We looked at the action plans the provider had sent us since the last inspection and we had spoken to commissioners of the service and the local authority safeguarding team.

We spoke with five people who used the service and observed others care in the communal areas. We spoke with one relative, the manager, nominated individual, operations manager and four members of the care staff team and a nurse.

We looked at five people's care records. We looked at systems the provider had in place to monitor the quality of the service.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection we had judged the provider to be inadequate in maintaining people's safety. At this inspection we found that some improvements had been made, however there were still concerns about people's safety. We saw that one person's care records stated that they became 'aggressive' on all personal care interventions. There was a care plan that stated that if this person refused personal care it must be carried out in the person's best interests. It was not clear how staff should safely support this person when they were being aggressive and staff we spoke with gave us conflicting information as to how this was carried out. This meant that this person was receiving care that put them and the staff at risk of injury during interventions.

We observed that this person was lying down in bed and a member of staff was trying to encourage them to have a drink. The staff member told us that they always slipped down the bed and they were able to have a drink in this position. We looked at the person's care records and other staff told us that this person should be sitting up to have food and drink by staff using a slide sheet to move the person up the bed. This was not the case and this put the person at risk of choking due to being in the prone position whilst drinking.

A new call bell system had been fitted since our last inspection and we saw that everyone had a call bell within reach. However we saw one person had a falls sensor mat by their feet to alert staff to when they were mobilising. We heard the sensor alarm sound as the person had got up from their bed to use the toilet. Two staff members were stood nearby and heard the alarm but did not respond in a timely manner. There were times when this person's falls alarm sounded and there was no staff members in the vicinity. We observed the person move from one side of the room to the other. This left the person at risk of falling as staff did not or could not respond in a timely manner.

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

Previously there had not been sufficient staff to be able to meet people's needs safely. We found numbers of people who used the service had decreased and the staffing levels had remained the same. The manager told us that they were actively recruiting to fill any staff vacancies and staff told us that the manager always filled any deficiency on the rota with agency staff. We were told that there was only one nurse on duty during the afternoon and evening and they spent most of their time administering medication. They were also responsible for the running of the home in absence of the manager such as managing staff and answering the phone. This left them with very little time to check the standards of care the staff were delivering. We discussed this with the manager who told us they would look into this and ensure nurse cover was adequate.

We found improvements had been made in the managing of people's medicines. New PRN protocols had been put in place for people who were prescribed 'as required' medicines. We saw one person was now encouraged to ask for their anxiety medicine when they needed it and this was working well and effective. We observed that medication was administered and stored safely by the trained nurses.

Previously people had not been protected from harm and abuse as staff had not recognised signs of abuse. We found that all the staff we spoke with knew what constituted abuse and told us they would report it to the manager. The manager demonstrated knowledge of the safeguarding procedures and told us that they had discussed several incidents with the safeguarding team; however they had not reached the threshold for further investigation.

Requires Improvement

Is the service effective?

Our findings

Previously we had concerns that the provider was not following the principles of The Mental Capacity Act 2005 (MCA) by ensuring that people were consenting or being supported to consent to their care, treatment and support. At this inspection the provider was still not following the principles of the MCA 2005. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Several people had a Do Not Attempt Resuscitation order (DNAR)'s. We could not see who had been involved in the decision making process for some of these people. We saw one person's DNAR had been signed by a relative. The nominated individual told us that the relative was the person's power of attorney so would rightly be able to sign to consent to the DNAR. However the nominated individual had not seen written confirmation that this relative had power of attorney rights for this person. This meant that the provider could not be sure that this person's relative had legal rights to make decisions on their behalf.

We saw one person had an active DNAR clearly visible at the front of their care file. Within the person's care file we saw that this person had capacity and had recently discussed the DNAR and decided that they did want resuscitation in the event of a cardiac arrest. The DNAR order had not been updated to reflect the person's change of decision. This meant that this person was at risk of not receiving the treatment they had requested at the time they needed it.

We saw records that one person had been told they couldn't have a cigarette at the time they requested one. This person's care plan stated they had capacity to make decisions for themselves. However the manager told us they had fluctuating capacity and could agree to some things and not others. This person had not had their capacity formally assessed. We saw a care plan that the person had signed to agree to only smoke under supervision with staff. An incident had occurred where the person had asked for a cigarette and was told they couldn't have one as they had one shortly before. This had upset the person and it was recorded they had become aggressive. The person's care plan did not stipulate a time frame between cigarettes. This meant that this person was being deprived of his liberty to have a cigarette when they wanted one and the option to change their mind to agree and consent to the plan was not being respected.

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

We saw one person was assessed at high risk of malnutrition. Their care plan stated that they should be weighed weekly and their food and fluid intake should be monitored. The person was prescribed food supplements which we saw were offered but refused on the day. The person's records did not clearly demonstrate what the person had actually had to eat and drink as we saw that there were gaps in recordings. We saw that the nurses had assessed the person's weight using the BMI tool which measures the circumference of the arm. Records showed that this person had lost a centimetre around the arm in a month, which meant they had lost weight. This had not been identified nor action taken to ensure that

medical advice was gained.

This was a breach of Regulation 14 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although some people had access to health care professionals when they needed it we saw that there were times when referrals to other agencies had not been made. For example, some people needed support with their mental health and would have benefited from a referral to a community psychiatrist. Another person needed referring to a dietician as they were losing weight.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). People were being unlawfully restricted of their liberty through the use of bed rails and other restrictive practises. The nominated individual told us they were aware that more DoLS referrals needed to be made. Previously people who lacked capacity to their care and treatment had not been referred to the DoLS team for authorisation of their care and accommodation at the service. Since our last inspection the manager had reviewed people's mental capacity and completed several referrals for people who lacked capacity to the DoLS team. This was to ensure that any restrictions to a person's liberty was the least restrictive and in their best interest.

Staff we spoke with told us that they liked and respected the new manager. They told us they were receiving regular support and had meetings with the manager to discuss their performance. Training was ongoing and the manager told us that they had extended the induction for new staff by a day as they felt that it had not been effective previously.

Good

Is the service caring?

Our findings

At our previous inspection people were not always treated with dignity and respect. The manager told us that they had discussed staff values with individual staff and had addressed issues of some staff's approach to people with them. At this inspection we observed that staff interacted with people in a kind and caring manner. One person who used the service told us: "The carers couldn't do any more than they do for me". We saw one person was distressed and we saw a nurse bent down to their level and offered them reassurance in a kind and compassionate manner. The person responded by saying: "I like you [nurses name]", and became calm and relaxed.

At breakfast we observed that people were offered choices of what they would like. We heard staff ask people if they would like warm or cold milk on their choice of cereals. Staff asked people if they wished to wear a 'dignity apron' whilst eating to save any spillages on their clothes. One person chose not to and the staff member responded by saying: "Ok no problem". This meant that people were being offered choices and their choices were being respected.

We saw another person was asked if they would like the curtains drawing in the dining room as the sun was in their eyes. This showed that staff were recognising issues that might make a person uncomfortable and acting on it.

Previously we had seen that some people were being cared for in bed with no duvet covers on their beds, the bedroom doors, curtains and windows had been open and two people had complained of being cold. We found at this inspection that bedroom doors were shut until people were ready to get up. We saw the bedding was clean and the rooms were warm and comforting. We saw nothing on the day which compromised a person's dignity. We had previously found a collection of people's personal toiletries in a communal bathroom and staff were unable to tell us whose they were. We found that people's personal toiletries were no longer kept in the bathroom but were in their bedrooms.

We had observed that some people had looked unkempt and untidy. At this inspection we saw that everyone looked well dressed in clean clothes, which reflected their personal preferences. One person told us: "I choose to have a bath twice a week and staff always support me with it".

We observed that a member of staff was filling in questionnaires with people about the service they received and if they would like anything more than was currently available. Residents and relative meetings were held and we saw that a relative had remarked that they could see improvements in the service.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection we found that not all people's assessed needs were being met. We had observed one person calling out for staff's attention and the staff had responded by asking them to 'sit down'. At this inspection a member of staff told us that they didn't support this person to get up out of bed too early as once they were up they constantly needed staff support. This meant that this person's needs were not being responded to in an effective manner.

We observed that another person frequently shouted out for help, this person had a mental health diagnosis. When staff were able to spend time with the person, they relaxed and were less distressed. However staff were unable to spend the time they needed to reassure the person and they were often left distressed.

Another person was being cared for in bed and had complex behavioural needs and was at high risk of malnutrition. We found that the provider was unable to meet this person's needs as staff had not received training in the management of challenging behaviour and this person was not receiving care that was safe and effective. The nominated individual and manager told us that they recognised that these people's needs were not being fully met by the service and that they would arrange a re assessment of their needs.

Previously people's care plans were not up to date and reflective of people's current care needs. We found that although some progress had been made, there were still some care plans that required up dating. For example throughout some people's care plans it would state that they had mental capacity to make decisions, however DoLS authorisations had been made for them. DoLS is only applicable for people without mental capacity to make decisions. This meant that the information in people's care plans were not reflective of people's needs.

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

At our previous inspection we found that the main lounge was overcrowded and people did not have the option to use other areas of the service due to them being closed for refurbishment. At this inspection we found that there were more areas for people to choose to sit. The main lounge was no longer overcrowded and some people sat in the upstairs lounge. The environment was calmer and more relaxed and we observed people were encouraged to try the new dining area that had been created.

Previously complaints had not been handled to people's satisfaction. We found that the new manager had received several complaints since being in post and had managed them through the formal processes. We saw that the manager responded to all complaints and investigated people's concerns. When action was necessary this was taken in a timely manner. We saw one example of a relative's response to the management of a recent complaint and that they were happy with the improvements made.

Requires Improvement

Is the service well-led?

Our findings

Since our last inspection there was new manager in post who was in the process of registering with us. Following the last inspection the nominated individual had sent us a weekly update on progress made towards improvements. We found some improvements had been made however further improvements were required and the provider continued to be in breach of five Regulations of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people were still not receiving care that met their needs. No action had been taken to assess these people's needs and gain the support and advice needed to ensure that people received care that reflected their current needs.

Systems were still not in place to ensure that all people consented to or were supported to consent to their care. Some people were at risk due to their mental capacity having not been assessed and ensuring that the right people were involved in the decision making process.

Some people's care plans did not always reflect people's current needs and left people at risk of receiving care that was not safe. For example the DNAR which had been left in the front of person's care plan when they had requested resuscitation.

The provider did not have a system to ensure that there were enough staff to meet people's needs. The staffing hours allocated were not based on people's individual needs.

These issues constitute a continued breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff and people who used the service told us they liked and respected the new manager. Staff told us they had met with the manager both individually and as a team. One staff member said: "It's good to have boundaries; we know where we stand with [manager's name]". Another staff member told us: "It's lifted us [manager's name] coming in, it's good for us, he's doing a good job". We found that there was a positive caring culture being adopted within the service. Staff told us that they had been spoken to by the new manager about their performance and accepted that they had needed to change.

The new manager held weekly 'manager surgeries'. These were for anyone to be able to approach the manager with concerns. We saw minutes of these surgeries and saw that several relatives had attended and made complaints, which had been managed formally. We saw that one relative had commented that they could see improvements being made.

The new manager told us that they wanted to advance the role of the nurse so that they held more responsibility. Nurses were now expected to complete hourly room checks to ensure that care had been delivered and people's bedrooms were left in an acceptable manner. We observed that people looked well cared for and their rooms were clean and tidy.

The new manager acted swiftly to manage and seek advice to make further improvements we had identified during this inspection.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive care that reflected their needs and individual preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People were did not always consent or were supported to consent to their care, treatment and support.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not always receive care that was safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People's nutritional l needs were not always met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

Further systems needed developing to ensure that people received safe, effective, responsive care.