

# Viomar Care Homes Limited

# The Old Vicarage

# Residential Home

## Inspection report

Vicarage Road  
Tean  
Stoke On Trent  
Staffordshire  
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Tel: 01538723441

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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?

Good 

Is the service well-led?

Requires Improvement 

# Summary of findings

## Overall summary

### About the service

The Old Vicarage Residential Home is a residential care home providing personal care and accommodation to 10 people aged 65 and over at the time of the inspection, some of which were living with dementia and/or a physical disability. The service can support up to 15 people in a single adapted building.

### People's experience of using this service and what we found

People's risk assessments were not always being followed. Some improvements to medicines management had been made, however further improvements were needed to ensure they were always managed safely. Systems were being embedded to ensure improvements were ongoing, however they had failed to identify some omissions, such as care plans not being updated and gaps in recording. People had access to other health professionals, however plans were not always updated with their advice. People's protected characteristics were not always explored further to ensure people were supported with these.

People were protected from abuse by staff understood their safeguarding responsibilities. There were sufficient numbers of suitably-recruited staff to support people. People were protected from the risk of cross infection. Lessons were being learned as feedback was being acted upon. Checks were taking place on the building and equipment to ensure it remained safe.

Staff received training to be effective in their role and felt supported. People were supported to have enough food and drinks of their choice, appropriate for their needs. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported practice. The environment had been partially redecorated and physical improvements had been made, with further plans in place.

People were supported by a kind and caring staff team. People were helped to remain independent and make choices about their care. Staff treated people with dignity and respect.

There were basic end of life plans in place, with improvements planned following our feedback. People were supported with their communications needs. People were able to partake in activities of their choice and staff were keen to develop this further. People were supported by staff who knew them well. There had been no complaints since our last inspection, but the manager was aware of their responsibilities.

Staff felt the manager was approachable and that they were effecting positive changes to the home. The home worked in partnership with other organisations. The manager was aware of their responsibilities in relation to duty of candour, the previous rating was being displayed and notifications were being submitted as required.

For more details, please see the full report which is on the CQC website at [www.cqc.org.uk](http://www.cqc.org.uk)

### Rating at last inspection and update

The last rating for this service was requires improvement (published 20 July 2019). It continues to be rated as requires improvement overall although there were some improvements to the rating for caring and responsive, which were now rated as good.

The provider updated us monthly about improvements they were making to the service following previous inspections.

### Why we inspected

This inspection was carried out to follow up on action we told the provider to take at the last inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Old Vicarage Residential Home on our website at [www.cqc.org.uk](http://www.cqc.org.uk).

### 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?

The service was not always safe.

Details are in our safe findings below.

**Requires Improvement** ●

### Is the service effective?

The service was not always effective.

Details are in our effective findings below.

**Requires Improvement** ●

### Is the service caring?

The service was caring.

Details are in our caring findings below.

**Good** ●

### Is the service responsive?

The service was responsive.

Details are in our responsive findings below.

**Good** ●

### Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

**Requires Improvement** ●

# The Old Vicarage Residential 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 was carried out by one inspector and an assistant inspector.

#### Service and service type

The Old Vicarage Residential 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 did not have a manager registered with the Care Quality Commission, although an application had been made by the provider to become registered. This application was still being considered at the time of the inspection.

#### 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 sought feedback from the local authority and we asked Healthwatch for any information they wanted to share. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. They had no information of concern to share. The provider was not asked to

complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

#### During the inspection

We spoke with one service user, one relative, three care staff, the deputy manager and the manager who was also the provider. We will refer to the provider as the manager throughout the rest of this report. We requested feedback from another health professional. We also made observations in communal areas.

We viewed a range of records. This included two people's care files and multiple medicines records. We looked at three staff files in relation to recruitment and staff supervision. The inspection team also looked at documents relating to the management and administration of the service such as audits, meeting records and surveys.

# 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 requires improvement. At this inspection this key question has remained the same. 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.

### Assessing risk, safety monitoring and management

- Risks to people were not always assessed and planned for.
- We saw two instances of moving and handling which did not match a person's plan. Their plan indicated they needed to be hoisted as using a stand aid caused them pain and they could not weight bear. Two staff on two separate occasions attempted to move the person using the stand aid. During the second occasion we asked them why they were not following the plan, they explained it was because the sling was not underneath the person, when it should have been. They later explained it was because the person was sometimes capable of using the stand aid and they would assess it each day. However, the staff were not assessed as competent to assess people's moving and handling needs. The person was not moved as they declined to be supported after staff had attempted to support them.
- Other staff members told us the person was not able to weight bear and the person's plan did not specify their fluctuating needs. This meant there was a risk the person was not being supported appropriately and they could come to harm if inappropriate equipment was used.
- Following our inspection, a physiotherapist assessed the person and agreed either the stand aid or hoist could be used to support the person.
- People had details about how staff should support them when they became agitated, staff knew how to respond during periods of agitation and we saw this happening.
- Personal Emergency Evacuation plans (PEEPs) were in place to help emergency services and staff identify how to help people evacuate people in the event of an emergency.

### Using medicines safely

At our last inspection the provider had failed to manage people's medicines safely. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements, so they were no longer in breach of the regulation, although further improvements were required.

- Medicines were not always managed safely.
- We found some stock discrepancies. There was a discrepancy for one person with a difference of one tablet compared to the Medication Administration Records (MARs). This was later explained as a recording error, as a staff member had recorded the medicine had been given, but it had not.
- We found another stock discrepancy of three tablets. The MAR indicated 28 tablets had been administered, so 28 tablets should be left in stock, however there were 31 in stock. Therefore, three had not been administered. There was no indication of the reason for this on the MAR. Therefore, the person was at risk of not having their medicine as prescribed.

- Another person had an inhaler, the records indicated there should be 15 doses of the inhaler left, however there were only 14 doses left. There was no indication on the MAR as to why this was the case, therefore the person could have had one dose too many.
- Two people had paracetamol prescribed as a regular dose of medicine. However, this was being treated as an 'as and when required' medicine, so was not being given as frequently as the prescription label stated. No one had come to any harm as a result of this, but it had not been reviewed by the prescriber to alter the prescription instructions.
- There were individualised protocols in place for medicines that people required 'as and when' medicine to help staff determine when they were needed.
- Checks were made on the temperature of the medicine fridge. These checks indicated the fridge was often at the maximum advised temperature of eight degrees Celsius, on one occasion it had gone up to 10 degrees Celsius which is outside of the recommended range and action to resolve this was not evident. However, as medicines were not being stored in there, so it did not pose a current risk to people.
- Topical creams and medicines prescribed as 'PRN' or 'as and when required' were being managed safely and staff had instructions to help them identify where and when they were needed.

#### Learning lessons when things go wrong

- Lessons were being learned. Accidents and incidents were being reviewed more regularly to check for trends. Feedback from previous inspections and from the local authority had been considered and measures were being put in place to make some improvements.

#### Staffing and recruitment

- There were enough safely recruited staff to keep people safe. One relative said, "I think there is more than enough staff. My relative never has to wait." People did not have to wait for support and staff had availability to spend time with people.
- Staff were safely recruited. There were appropriate pre-employment checks made prior to them starting and measures put in place if anyone had a conviction on their DBS, to protect people.

#### Systems and processes to safeguard people from the risk of abuse

- People were protected from the risk of intentional abuse and people felt safe. One person said, "I feel safe, I can call them at any time."
- Staff all knew the different types of abuse, how to recognise these and were aware of their responsibilities to report this. We saw appropriate referrals were being made to the local safeguarding authority.

#### Preventing and controlling infection

- People were protected from the risk of cross infection. The home was clean and tidy.
- We observed staff wearing aprons and gloves at appropriate times.
- Environmental health had inspected the kitchen and given it a rating of four out of five for food hygiene rating in October 2018.



# 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 requires improvement. At this inspection this key question has remained the same. 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; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- People had care plans in place about their health conditions, although these were not always updated when advice changed.
- For example, one person needed support to keep their hand healthy. Health professionals had been consulted and prescribed a treatment plan, however this was not reflected in their care plan. A new prescription had been provided 12 days prior to our inspection; we saw that the use of the prescribed treatment was being recorded on a MAR. However, prior to this the person still needed hand support every day, but there were multiple gaps in the recording of the daily hand care, so we could not always be sure they were supported appropriately.
- The same person also needed support with their continence. They needed support by home staff to change a piece of equipment every seven days. Records showed on two occasions they went for ten days and eleven days without this being changed. This could put them at risk as equipment may not be clean or robust enough.
- People had access to other health professionals. One relative said, "My relative had a bump. They [staff] called the ambulance."
- We saw there was support from regular visits from a local advanced nurse practitioner and other professionals visited, such as podiatrists. Support was accessed from the GP, 111 NHS number and attending hospital when necessary.

Staff support: induction, training, skills and experience

- Staff training received training to be effective in their role. One relative said, "They seem to know what they are doing."
- Staff confirmed they received training and the manager kept a record of this on a training matrix.
- Staff felt supported by the manager. Staff received supervisions and plans were in place to ensure all staff had a supervision when they were newly employed.

Supporting people to eat and drink enough to maintain a balanced diet

- People were supported to eat and range of food and drinks of their choice, appropriate to their needs. One person said, "The food here is excellent, I have always been a good cook, but the food here is great."
- People had a choice of meals. People that needed a pureed diet received this and they were pureed separately so they could choose which parts of the meal they ate.

- People's food and fluid intake was monitored when necessary and plans in place if people regularly did not meet their targets. People's weight was also monitored to ensure they remained healthy.

#### Adapting service, design, decoration to meet people's needs

- The environment was in the process of being improved. New carpets had been fitted, new equipment purchased, and the fabric of the building was being improved, such as new windows.
- Appropriate checks were being made on the building and contents to ensure they remained safe to use.

#### 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.

- Staff understood what capacity meant and were aware of people who struggled to make decisions.
- Decision-specific mental capacity assessments were being carried out and decisions in people's best interests were being recorded.
- DoLS referrals were being made if there were restrictions on people.

# 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 requires improvement. At this inspection this key question has improved to good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

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

- People were well treated. One person said, "I think it is absolutely fabulous, all the staff have a smile on their face."
- One relative said, "I couldn't ask for a nicer place."
- We observed many caring interactions. For example, during lunch some people needed to be supported with their meals. This was done with patience and staff spoke with people being supported.
- In another example, when a person was becoming agitated, staff responded appropriately to avoid making the person more upset and they recognised when the person did not want to be supported.

Respecting and promoting people's privacy, dignity and independence

- Staff supported people's privacy and treated people with dignity. People's independence was supported.
- Staff spoke with respect to people and spoke with them at eye level to ensure a more meaningful interaction. Staff explained any support they were offering, such as during moving and handling, to reassure people.
- We observed staff checking people's consent prior to putting protective aprons on them at meal times, so people could choose whether they wanted to wear these.
- People were supported to be independent; they could choose where they spent their time and we observed some people stay in their room and other in communal areas. People were encouraged to eat independently and to enjoy activities with one another.

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

- People were involved in decisions about their care. One person explained they had decided for staff to look after their medicines and they remained independent with some areas; "I choose for the staff to give me my medication, I know exactly what tablets I take... I buy gel to rub on my joints, I sort this out myself."
- People were able to choose where they spent their time, some people preferred to remain in their room, whilst the majority of people spent time in the lounge.
- Staff were able to explain how they supported people to make decisions if they struggled.

# 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 requires improvement. At this inspection this key question has improved to good. This meant people's needs were met through good organisation and delivery.

### End of life care and support

- No one was receiving end of life support at the time of our inspection, but consideration had been given to ensure people had a pain-free and comfortable death.
- Care plans were in place which detailed people's religion, if they had one, and their choices about their after-death wishes. However, these did not go into detail about people's personalised preferences for the days and weeks prior to their death and how they wished to be supported. For example, people may want to wear specific clothing listen to specific music or do certain activities should they be able to.
- Following our feedback, a revised end of life form was put in place with more prompt questions to try and implement more personalised plans of care.

### 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.

- Care plans detailed people's communication needs; we observed people were shown photos of meal options and received explanations about choices to address their communication needs.
- The manager was aware of AIS and explained they had a policy in place. They were able to tell us how a person with a visual impairment was able to access information.

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

- People had the opportunity to engage in hobbies and activities or their choice. One person found rolling up wool or colouring in was comforting and we observed staff assisting them to access these activities. We were told of singers visiting the service.
- One relative said, "They do flower arranging. I've seen all sorts being done. Tuesday is glamor day, the hairdresser comes. Three people go to knit and natter club on a Friday."
- We were told of events that took place, such as afternoon tea to include both people and relatives, a summer BBQ and they threw birthday parties for people.
- People received visitors and could be supported to leave the home whenever they chose to. We observed people coming and going throughout the day.
- Staff were keen to develop the range of activities available, which they had fed back in a recent staff survey.

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

- People felt well supported and staff knew people well. One person said, "I wouldn't change anything about this home, I get everything I ask for."
- We observed people being offered choices and being supported when they became agitated in a way that met their needs. A relative also told us their relative became agitated and they were contacted to try and calm the person down. However, when they arrived staff had engaged them in activity and comforted the person, which calmed them down.
- Staff told us they felt able to get to know people, one staff member said, "I know the residents well, I know about their needs and about their backgrounds, likes and dislikes; it is in the care plans and just talking to people and getting to know them."

Improving care quality in response to complaints or concerns

- No complaints had been received since our last inspection. The manager was aware of their responsibilities to investigate and respond to concerns raised.

# 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 requires improvement. At this inspection this key question has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created 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

At our last inspection the provider had failed to robustly monitor and improve the quality and safety of people's care. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 17. New systems were in place to monitor the service and previous feedback had largely been acted upon.

- Whilst quality assurance systems had been introduced these had not yet been fully embedded to ensure they were consistently effective and sustainable.
- Medication audits had been introduced to check stock levels and medicines that had been carried forward from previous months were now being recorded. We saw some medicines had different stock levels than expected but the reason for this was not recorded on the MAR. This had not been picked up by staff. The manager later explained in relation to one instance that the staff member had recorded elsewhere they had dropped a tablet. The manager explained the audit to check this had not yet taken place as our inspection took place at the time it would normally be carried out. However, staff had still not identified this during their day to day checks.
- Two people had paracetamol prescribed to be administered as a regular dose, however it was being treated as a PRN medicine. Systems had not identified this and action had been not taken to ensure the prescription was reviewed. People did not come to harm as a result of this, but action had not been taken to have the prescription revised the reflect people's needs and choices.
- One medicine had specific instructions about food that could not be eaten whilst the medicine was being taken. The kitchen had been made aware of this, however the instructions were not on the MAR chart and this had not been identified as missing information during audits.
- An audit had taken place on two people's care files which had failed to identify or explain why people's care plans did not always match their current needs; such as people's moving and handling needs, catheter care and hand care needs. This meant there was a risk some people not always be supported consistently, and systems had failed to identify this.
- We observed one person not wearing their glasses for most of the day until a staff member went to get them in the afternoon. This could have impeded the person's ability to communicate until they were wearing them.

- We also observed the manager speaking to someone on their right side, but the person's plan detailed that they were hard of hearing on the right side and were better listening on their left side. This meant their plan was not always being followed.

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

- People, relatives and staff were asked for their opinion about the service, relatives were asked for feedback as part of reviews and surveys.
- Feedback from surveys had been collated, was positive overall and comments from staff had been acted on.

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 manager was aware of their duty of candour and could explain to us the action they would take. They said, "It's about being open and transparent, learning from it and being open so people know. We'd do it [apologise] in writing and put it right."
- The provider and manager were open to feedback from our inspection and took steps to implement improvements following issues we identified.

Continuous learning and improving care

- The service was using feedback to learn and improve care. Conditions on the service's registration had been complied with and had assisted the manager in making some improvements.
- Whilst improvements were still needed to the service, many things had been put in place to improve people's quality of care. Staffing had improved, more plans for people's health needs were in place and although there were some improvements needed to medicines, the management of these had improved at each inspection.

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

- There was a positive culture and staff felt able to approach the management team. One staff member said, "The manager is lovely, they work really hard in all areas of the care home. They are approachable, and I would be happy to talk to the manager confidentially."
- Another staff member commented, "The manager is fine, no problems, I can go to them and feel part of the team" and they went on to say, "I think this is a good place to work, from the first day I came here I could tell it was going to be good, it was a happy place, the residents were well presented with their jewellery. I look after the residents like I would look after to my own."

Working in partnership with others

- The service worked in partnership with other organisations. The manager explained they had made links with other managers from other local services they could contact to share best practice. They also explained they had signed up to 'Skills for Care', a national organisation that aims to provide support and guidance to improve services.