Hewitt-Hill Limited

# The Old Vicarage

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

| | |
|---|---|
| Is the service safe? | **Inadequate** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

About the service
The Old Vicarage is a residential care home providing accommodation and personal care for up to 41 older people. At the time of our inspection there were 39 people using the service.

The Old Vicarage comprises the main home for up to 29 people, and a new building for 12 people. The new building provides spacious rooms, and there were small outside spaces attached to each room. The main home has a dining area which all people had access to and pleasant outdoor areas with seating.

People's experience of using this service and what we found
Significant improvement was needed to ensure people always received good quality, compassionate, individualised and safe care as a minimum standard.

People were not supported safely. Risks to people were not always robustly assessed and mitigated. Staff did not always have the information they needed to provide safe care because risks associated with people's care had not always been fully assessed. This included for falls, diabetes, and choking. Medicines were not always safely managed. There were not sufficient numbers of suitably skilled staff to make sure that they could meet people's care and support needs. Staff were not always recruited safely.

Infection prevention and control was not well managed. We found the service to be unclean in multiple areas including people's rooms, the main kitchen, and laundry. Staff were not disposing of PPE safely.

People were mostly 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 this practice. Further work is needed to ensure mental capacity assessments and best interest decisions are in place for all aspects of people's day to day care, but work had begun on this.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic. Staff received training in learning disabilities, however, the registered manager was unaware of the statutory guidance.

The service lacked effective leadership and risk management. The provider's systems for monitoring and improving the quality of the service had not been effective, because people were not always receiving a good quality of service and some risks had not been mitigated. This placed people at continued risk of harm.

The provider was responsive to the inspection findings, they told us they were willing to learn, improve and share the actions they would take to address the issues found at this inspection.

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 18 May 2019).

Why we inspected
We received concerns in relation to environmental risks, infection control and staffing. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

You can see what action we have asked the provider to take at the end of this full report. The overall rating for the service has changed from Good to Inadequate based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Old Vicarage on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to safe care and treatment, medicines, infection control, staffing, recruitment, governance and reporting procedures at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Inadequate**

The service was not safe.

Details are in our safe findings below.

### Is the service well-led?

**Inadequate**

The service was not well-led.

Details are in our well-led findings below.

# The Old Vicarage

**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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by 3 inspectors (one of whom specialised in medicines) 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 is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. The Old Vicarage is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection

This inspection was unannounced.
Inspection activity started on 21 June 2023 and ended on 14 July 2023. We visited the service on 21 June 2023.

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 professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We reviewed support plans and associated records for 7 people. We reviewed medicine administration and associated records for 14 people, observed medicines being given to people and we spoke with 2 members of staff about medicines. We spoke to 8 people who lived at the service and observed staff delivering care. We spoke with the registered manager, deputy manager, activity co-ordinator and compliance manager.

After the inspection we received further documentation electronically, such as governance audits, supervisions, and minutes of meetings. We spoke with 8 relatives, the head cook, and 1 cleaner. We continued to liaise with the local authority about our concerns following the inspection.

Inadequate

# Is the service safe?

## Our findings

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

At our last inspection we rated this key question Good. At this inspection the rating has changed to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Preventing and controlling infection; Using medicines safely

- Staff did not always have the information they needed to provide safe care because risks associated with people's care had not always been fully assessed. This included for falls, diabetes, and choking. This meant people people were at risk of receiving care which did not meet their needs and which placed them at risk of harm.
- There were a high number of falls in the service. Where people had fallen multiple times there was a delay on referring some people to specialist falls teams. This meant we could not be sure that all actions to reduce risk of further falls were in place.
- The environment was not safe in some areas. Window restrictors were not fitted on the lower floor of one corridor to comply with Health & Safety Executive (HSE) guidance. There were items such as metal ramps hung close to a person's room with sharp edges, and a 2-foot drop in front of an unlocked storeroom which could have caused a potential injury had a person attempted to enter the room.
- People lived in an unclean environment and were not protected from the risk and spread of infection. Adequate systems were not in place to prevent and control the spread of infection. This included in people's bedrooms, communal areas, the main kitchen, and laundry.
- We found the environment to be poorly maintained in some areas.
- Not all staff had received infection prevention control training. This posed a risk in relation to managing and minimising the risk of infection. Staff were not disposing of PPE (personal protective equipment) in a safe way.
- Records in the main showed people received their oral medicines as prescribed. However, we noted that for one person, on two recent occasions incorrect doses of their high-risk medicine to help prevent blood clots had been given to them placing their health and welfare at risk.
- There were gaps in the records of the application of some people's medicines such as topical skin creams and emollients.
- We saw that the morning medicine round was lengthy. We noted that one person received their medicine for diabetes much later than with their breakfast when it was intended. Another person received a medicine later than scheduled that was also due at lunchtime which could increase the risk of adverse effects from it.
- When people were prescribed medicines on a when required basis (PRN), there was sometimes a lack of written guidance for staff to refer to about some medicines prescribed in this way. When more than one pain-relief medicine was prescribed PRN for people there was a lack of detail about the overall pain-relief strategy for the person's pain.
- When people were prescribed medicated skin patches, there was a lack of records to show when the previous patches had been removed. In addition, records showed that the position on the person where the

patches had been applied had not always been appropriately rotated to reduce the risks of adverse effects from the patches..
● For people who could have their medicines given to them concealed in food or drink (covertly), assessments and best interest decisions had been formed. However, records did not show that all relevant healthcare professionals had been consulted with. For some people having their medicines given covertly, written information for staff to refer to about how to have their medicines was inconsistent and unclear.
● We identified medicines risks around a person self-administering some of their medicines and the use of paraffin-based topical medicines and the associated fire risk across the service and asked the service to put in place appropriate risk assessments.

Systems and processes did not demonstrate risks were always identified, assessed and mitigated. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Due to the seriousness of our findings, we wrote to the provider to ask them for further information relating to specific risks. We received information which provided assurances that the most urgent risks would be mitigated promptly.
● Checks for fire safety were in place. There was a system to reduce the risks of legionella bacteria in the water system.

Staffing and recruitment
● Sufficient numbers of staff were not provided on shift. The dependency tool used to calculate the number of staff required was being completed incorrectly. This meant that staffing levels were below what was required to keep people safe. We observed that people calling staff for assistance were not responded to in a timely manner. We observed that one person remained in a soiled bed for over 20 minutes before staff responded, at our request.
● People told us there was not enough staff to respond. One person said, "This is a brand new wing opened last August, 1 staff monitors all 12 rooms, whereas [there are] 3 or 4 staff for the rest of the residents. They said at the last residents meeting that there would be one staff who would be a spare, but it has not happened." Another said, "I call staff with the buzzer, they come in 5 minutes or sometimes an hour, only 1 staff for 20 people."
● The provider had not ensured that sufficiently skilled staff were deployed to ensure they could meet people's care and treatment needs. Multiple staff were non complaint with mandatory training which placed people at risk of significant harm.

This constituted a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● When we brought these concerns to the providers attention, they promptly increased staffing levels and implemented relevant training for staff via their 4 in-house trainers.

● We could not be assured that staff were recruited safely, or that the provider was regularly reviewing the fitness of employees. Disclosure and Barring Service (DBS) checks for 2 staff members were last completed in 2004. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● Photo identification was not held on recruitment files for 2 staff.
● Not having robust recruitment checks in place meant the provider could not be assured that staff were fit to work with vulnerable people.

This constituted a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● Actions to report concerns about people's safety were not always sufficient. This meant we could not be assured that there was independent oversight to ensure people were fully protected.
● Where incidents had been referred to the local authority safeguarding team, the registered manager had not always informed the CQC of these which is required by law.
● Not all staff had received training in safeguarding adults to ensure they had a good knowledge on how to respond to incidents of potential abuse.

Learning lessons when things go wrong
● Systems were not fully embedded into care practice or robust enough to demonstrate incidents were effectively monitored, reviewed or used as a learning opportunity. This meant people were placed at risk of on-going harm.
● Audits relating to the analysis of incidents and accidents were completed. However, the findings were not used to improve quality and safety for people. For example, 2 audits showed a high trend on the time that people were most likely to fall, but no consideration had been given to implementing additional staffing at this time.
● Our inspection findings evidenced the quality and safety of the service had significantly deteriorated since our last inspection.

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

● We found the service was mostly working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.
● The service had begun implementing mental capacity assessments and best interest decisions in relation to people's day to day care and treatment, following feedback from the local authority that this required improvement.

Visiting in care homes
● Relatives we spoke with informed us that they were able to visit their loved ones at the home.

Inadequate

# 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 our last inspection we rated this key question Good. At this inspection the rating has changed to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- Audits had been completed to monitor the quality of the service, but these had not identified and resolved the multiple shortfalls we found. Where trends had been identified, action was not taken to mitigate risk to keep people safe.
- The provider's oversight and monitoring systems and processes were ineffective and failed to appropriately manage risks to people and ensure adequate numbers of skilled staff were deployed. We observed people were not responded to in a timely manner, including when people needed support with their continence. This impacted on their dignity.
- People did not consistently receive safe care. We identified shortfalls in the management of risk, medicines, and care planning.
- People's safety in relation to recurrent falls had not been considered as a potential safeguarding concern. There were trends in the times that people had fallen but this had not been acted on to reduce risk.
- The systemic failings outlined in this report demonstrated the provider had failed to ensure people received a well-managed service which was safe and compassionate placing people at risk of potential harm.

This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following the inspection, the provider worked closely with CQC to address the shortfalls found. They responded promptly to concerns and implemented additional staff and training.
- There was a registered manager in post, supported by a deputy manager.

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 not notified the CQC about 5 safeguarding incidents which is required by law.
- This created an ongoing risk of harm, limited the provider's ability to respond to these risks and meant we could not alert other organisations should there be a need.
- The provider's oversight of the service had not identified this situation. This meant there were missed opportunities to make changes to prevent recurrences if needed.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

● The provider was open and honest about the failings in the service, and worked with CQC to rectify immediate risks, and appointed a care consultancy company to support on-going improvements that were needed.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● People did not always achieve good outcomes or receive person-centred care. We observed that staff would sometimes turn off a call bell, and tell the person they would come back later.

● People did not live in a safe and secure environment. Obvious risks to people's safety had not been identified and/or acted on.

● The provider had not ensured all staff had completed relevant training to support people using the service safely and effectively. This meant that staff may not be sufficiently skilled to support people in an emergency situation.

● Staff told us they attended staff meetings and felt supported, but not always listened to when concerns were raised. One staff member told us that since the inspection additional meetings had been arranged with the provider, which they thought was much needed.

● There had been relatives and residents meetings. The minutes of the meeting showed that several residents had raised concerns about staffing levels in March 2023. Feedback from people during this inspection showed this was still an issue for them, with several giving examples of having to wait for staff sometimes up to an hour.

● Resident surveys were not available to review. The provider told us this was an areas requiring improvement.

Continuous learning and improving care; Working in partnership with others

● Referrals to falls prevention teams were not always made in a timely manner to ensure people had access to specialist advice and provision of equipment to mitigate risk. This limited the provider's ability to gain learning and share this with relevant staff which put people at risk of harm.

● Staff tried to ensure people were referred to and reviewed by external health professionals such a SALT (Speech and language therapy). However, care records did not always reflect up to date information about recommendations made by professionals involved in people's care and treatment.

● Effective systems were not in operation to support a culture of learning and improvement. The provider had not ensured that its workforce was adequately trained and skilled to work with vulnerable people, many of whom were living with complex needs.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 Registration Regulations 2009 Notifications of other incidents<br><br>The registered manager had not informed CQC of 5 safeguarding incidents.<br><br>18 (1) (2) (e) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Risks to people were not well managed. Infection control procedures were poor across the service. Medicines were not always safely managed.<br><br>12 (1) (2) (a) (b) (h) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Governance systems had failed to identify where improvements were needed. People did not receive a safe service as the leadership and oversight was not robust.<br><br>17 (1) (2) (a) (b) (c) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>Recruitment procedures were not robust. |

| | |
|---|---|
| | The provider did not regularly review the fitness of employees.<br><br>19 (1) (a) (5) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Staffing levels were not sufficient and staff were not compliant with training.<br><br>18 (1) (2) (a) |