Aegis Residential Care Homes Limited

The Old Vicarage Care Home

Inspection report

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Date of inspection visit:
02 April 2019
04 April 2019
08 April 2019

Date of publication:
08 July 2019

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 Care Home provides personal care and support for up to 35 older people. At the time of the inspection 28 people were receiving support with personal care.

People's experience of using this service:
Medicines were not managed safely which placed people at risk of harm.

People told us they received help from staff when they needed this and staff came quickly to support them.

People were enabled to express their views on their experiences of receiving care and support. People were encouraged to share their experiences of living at the home with staff and the management team.

Safe recruitment procedures were used to help ensure prospective employees were of suitable character to work at the home.

People told us they felt safe with staff and staff told us they would report concerns of abuse or avoidable harm to the manager and local safeguarding authorities to protect people.

Rating at last inspection:
At the last inspection the service was rated requires improvement (published 18 January 2019).

The service has been rated requires improvement for the last five consecutive inspections.

Why we inspected:
We carried out this focused inspection to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection in October 2018 had been taken.

Enforcement:
We have identified breaches in relation to management and oversight of medicines and in relation to the oversight and governance of the service. We have imposed conditions on the registration for this location to address the management and oversight of medicines.

Follow up:
We have asked the registered provider for an action plan to show how they will make and sustain improvements.

We will liaise with the local authority and clinical commission group to ensure all required actions are completed to ensure the health and welfare of people who live at the home.

The next scheduled inspection will be in keeping with the overall rating. We will continue to monitor information we receive from and about the service. We may inspect sooner if we receive concerning information about the service.

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

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 Care 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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection was carried out by two adult social care inspectors and a pharmacist member of the medicines team. The first day of the inspection was carried out by a pharmacist inspector and two adult social care inspectors. On the second day, an adult social care inspector visited the home to look at information gathered since the first day of the inspection. On the third day of the inspection, an adult social care inspector and a pharmacist inspector visited the home to discuss the safe management of medicines and review further information.

Service and service type:
The Old Vicarage Care 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 Old Vicarage Care Home accommodates up to 35 people in one house.

At the time of the inspection there was no manager registered with the Care Quality Commission. A registered manager application was in process. Once registered, 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:
The inspection visit took place on the 02, 04 and 08 April 2019. The first day of the inspection was

unannounced.

What we did:
Before our inspection we reviewed all the information we held about the service and completed our planning tool. This included notifications we had received from the provider, about incidents that affect the health, safety and welfare of people who received support and information from members of the public. We contacted the local funding authority and asked them their views on the service provided. We used all information gained to help plan our inspection.

During the inspection we spoke with five people who received support and two relatives. We also spoke with the quality manager, manager and deputy manager. We reviewed five care records relating to people who received support and looked at medicines and records about medicines for 17 people. We also spoke with one senior carer who had responsibility for administering medicines on the day of the inspection. In addition, we reviewed documentation relating to the management of health and safety at the service, training records and three staff personnel files. During the inspection we also spoke with a housekeeper, a maintenance person and two care staff.

Inadequate

Is the service safe?

Our findings

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

People were not safe and were at risk of avoidable harm. There were continuing shortfalls in the management of medicines. Some regulations were not met.

Using medicines safely

At the last inspection carried out in October and November 2018, we found medicines were not managed properly and safely. This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014 (Safe care and treatment). We issued a Warning Notice to make sure swift improvements were made in the safe management of medicines.

At this inspection, carried out in April 2019, we found the Warning Notice was not met. Medicines continued to not be managed safely in the home.

- Staff did not always follow the prescribers' directions and people were not always given their medicines as prescribed. Stock checks for some people's medicines showed they had not been given as prescribed.
- People were at risk of being given doses of their pain relief too close together, because staff did not record the times doses were administered.
- One person missed some doses of their prescribed medicines either because there was no stock available or staff failed to give the medicine when it came back into stock.
- People did not always have written guidance in place for staff to follow when they were prescribed medicines to be given "when required" or with a choice of dose. When guidance was in place it was not always sufficiently detailed.
- Records about medicines did not always show that medicines were managed safely. Records of administration were not always completed accurately because there were gaps on the charts. The quantity of medicines in stock was not always recorded so it was not always possible to determine if medicines had been given properly. Records about the application of creams did not to show creams were applied as prescribed.

This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safe care and treatment).

Assessing risk, safety monitoring and management

- Staff told us they followed the risk assessments to ensure people were protected from the risk of avoidable harm. Staff recorded information on how people's safety could be promoted in care records. Staff carried out risk assessments on areas such as the nutrition, falls and skin integrity. These were reviewed regularly and updated to reflect changes in people's needs and circumstances.
- Systems were in place to ensure equipment was checked and safe for use.
- The provider had a fire risk assessment and had developed an action plan based on the outcome. The

action plan showed all actions had been completed.

Staffing and recruitment

● Staff were recruited safely. Managers carried out pre-employment checks including Disclosure and Barring Service checks before staff started work at the service. References were obtained to help ensure people were supported by staff who were suitable to work with vulnerable people.

● Sufficient numbers of staff were deployed to meet people's needs safely. People told us they were supported by staff quickly if they needed help and we saw people were supported promptly on inspection. One person told us, "I feel safe because when I ring for help they come and help me." The manager planned rotas in advance to ensure sufficient staff were available to support people.

Systems and processes to safeguard people from the risk of abuse

● People were protected from the risk of abuse. People told us they felt safe. One person told us, "I'm safe here, the staff look after me. They make sure of that."

● The provider had safeguarding procedures and the number of the Lancashire Safeguarding Authority was accessible to staff, so concerns could be raised if needed. Documentation showed staff made appropriate referrals if required.

● Staff could explain the purpose of safeguarding and the action they would take if they had concerns. One staff member told us they would report concerns to protect people from harm. They told us, "All safeguardings are investigated so people are protected."

Preventing and controlling infection

● People were protected against the risk of infection. Staff told us they completed infection control training and they could access personal protective equipment to help minimise the risk and spread of infection.

● The home was visibly clean. The housekeeper told us they followed cleaning schedules to maintain the cleanliness at the home. We noted some areas of the home were malodourous. We discussed this with the manager who took swift action to rectify this during the inspection.

Learning lessons when things go wrong

● The registered manager reviewed accidents and incidents to identify trends and themes. We saw they acted, whenever possible, to minimise the risk of the same incident happening again.

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

There were continuing shortfalls in the management and oversight of medicines. Leaders did not assure the delivery of high-quality care. Some regulations were not met.

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

During this inspection carried out in April 2019 we found not all fundamental standards had been met and the service was rated as inadequate. This is following the service being rated as requires improvement at the previous five inspections. This demonstrated oversight and governance of the service was inadequate.

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

● At the time of the inspection the manager was not registered with the Care Quality Commission. A registered manager application was in process.
● Staff told us everyone worked together to make people's experience of The Old Vicarage Care Home a positive one. Staff told us they attended staff meetings where they were informed of what needed to improve and how this could be achieved.
● The manager said they kept their knowledge up to date by attending training courses and local best practice events.
● Management had notified us of certain events, as required by regulation, and ratings from the previous inspection were displayed at the service.

Continuous learning and improving care
● At the last inspection carried out in October and November 2018, we found medicines were not managed properly and safely. The fundamental standard was not met and a Warning Notice was issued. At this inspection, carried out in April 2019, we found the Warning Notice was not met. Medicines continued to not be managed safely in the home. The manager had completed audits to check medicines were being managed safely, but these had not picked up the concerns we found during our inspection. This was a failure to learn and improve to meet fundamental standards.
● Members of the management team carried out checks and audits to identify any areas of improvement. These included equipment checks, infection prevention control and accidents and incidents.
● The manager investigated accidents and incidents and took action to minimise the risk of them happening again. For example, one person shared they had fallen prior to moving to the home. They told us this had been discussed with them and they had agreed to use equipment to help minimise the risk of falling.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

● People told us they could speak with staff about anything they wished and were confident staff and the manager would respond to them. One person told us the manager was pleasant to talk with and commented, "Everything seems to run smooth enough." Another person told us they knew the manager and they felt the home was managed, "Well."

● Policies and procedures provided guidance around the duty of candour responsibility if this was required.

● Staff told us they liked working at The Old Vicarage Care Home. They told us they were supported and could seek guidance and clarity from the manager. One staff member told us, "The support is there." Another staff member told us they felt the manager and deputy manager worked as part of a team and they were able to approach members of the management team if they wished to do so.

● Contact details for management and senior management were displayed within the home on a notice board. This meant staff, visitors and people could contact members of the management team if they wished to do so.

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

● The manager sought to engage with people who used the service. Nominated staff wore badges to indicate they had 'a listening ear' and could support people to complete comments cards. Cards and pens were available in people's rooms and a comments box was located in a lounge at the home.

● The manager told us this was a new initiative and one card had been received at the time of the inspection. We viewed this and saw the feedback was positive. Staff we spoke with were aware of the initiative. They told us, "It helps us hear their voice."

● 'Relatives and residents' meetings took place, so information could be shared and feedback gained.

● Staff told us and we saw documentation that showed staff had individual meetings with their line manager to discuss their performance and any concerns they may have. This allowed discussions to take place on any areas where staff required support or guidance and staff could share their views if they wished to do so.

Working in partnership with others

● The service had liaised with health care professionals to ensure timely referrals were made and where necessary additional support had been sought. This ensured a multi-disciplinary approach had been taken to support care provision for people in their care.

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 17 HSCA RA Regulations 2014 Good governance The registered provider and management had not operated effective systems and processes to ensure the service met fundamental standards and consistent improvements were made. Regulation 17 (1) (2) (a) (b) (e)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed properly and safely. Regulation 12 (1) (2) (g)

The enforcement action we took:

We imposed a condition on the registered provider's registration for this location.