Aegis Residential Care Homes Limited

The Old Vicarage Care Home

Inspection report

15 Naze Lane
Freckleton
Lancashire
PR4 1RH

Tel: 01772635779
Website: www.pearlcare.co.uk

Date of inspection visit:
19 April 2016

Date of publication:
29 June 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The Old Vicarage is a residential care home accommodating a maximum of 31 older people including older people who live with dementia. Accommodation is provided on two floors. A passenger lift is available. There are several communal lounges, a separate dining area and an enclosed garden.

There were 24 people using the service at the time of the inspection.

At the time of the inspection the service did not have a registered manager in place. However, a new manager had been recruited and intended to apply for registration with the commission. 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.

The last inspection of the service took place on 8 & 13 October 2015. During that inspection we found the service was in breach of a number of regulations relating to person centred care, consent, safe care and treatment, safeguarding people from abuse and improper treatment, meeting nutritional needs, good governance, staffing and recruitment.

We found during this inspection that a number of significant improvements had been made. However, we identified a number of areas where further improvements were required and we still had outstanding concerns about medicines management.

The overall management of medicines was much improved. We found that there were clear medicines records in place for each person who used the service, which included all the required information. We also noted that medicines were now stored in a safe and appropriate manner. However, during the inspection we found that some errors had occurred, which resulted in two people receiving their medicines at the wrong times and another person not receiving some medicine for a period of four days, because the stock had run out. This meant that people did not always receive their medicines as prescribed.

At the last inspection of the service carried out in October 2015, we found that risks to people's safety and welfare were not always assessed or managed well. We found during this inspection that procedures for risk assessment and care planning were much improved and care workers had a good understanding of the measures required to promote people's safety. However, we found that people's individual risk management plans and PEEPS (Personal Emergency Evacuation Plans) could have contained more individualised guidance to further support their safe care and treatment. We made a recommendation about this.

During the last inspection in October 2015, we found that the provider did not always ensure there were adequate numbers of suitably qualified and competent staff on duty to meet people's needs safely. During

this inspection we found there had been much improvement to staff training and that staffing levels were determined in line with the needs of people who used the service. However, some people we spoke with told us they felt they had to wait for assistance at times and we also noted that staff were not always present in some communal areas of the home, such as the lounge. We made a recommendation that the manner in which staff are deployed across the service is reviewed.

We found recruitment procedures were more robust. The provider was able to demonstrate that due consideration was given as to whether applicants were suitably qualified to carry out the role they were applying for and all applicants were subject to a range of background checks to help ensure they were of suitable character. However, further potential improvements to the recruitment processes were needed.

Everyone we spoke with including people who used the service, their families and community professionals felt the home had been much cleaner since the last inspection. People were very satisfied with the standards of cleanliness and hygiene. A lead person had been appointed for the area of infection control and improved infection control procedures were in place. However, we did note some areas and equipment to be visibly unclean. In addition, some parts of the home were found to be malodorous.

At the last inspection in October 2015 we found that the service did not always obtain legal consent from people who used the service and we also found some examples where the service had failed to seek appropriate authorisations to make decisions on people's behalf about their care and accommodation. During this inspection, we found that the service properly considered people's mental capacity to consent and ensured that any decisions made on people's behalf were done so with the correct authorisations. However, we found that information relating to people's capacity and any authorisations in place, could have been better recorded in their care plans. We made a recommendation about this.

Most people felt that they received care that was person centred and that met their personal needs and preferences. In addition, people in general felt that staff at the home communicated well with them about their or their loved ones' care. However, this was not the experience of everyone we spoke with. We made a recommendation that the manager consider the views of people who felt communication and opportunities to be involved in their care could be improved.

People reported positive experiences of care and told us they found the staff to be kind, caring and respectful. People also felt their privacy and dignity was respected. However, we found that some people's privacy and dignity had been compromised, due to personal information about them being left in view within their bedrooms or en-suite facilities. We made a recommendation about this.

Arrangements for monitoring safety and quality across the service were much improved. We saw there were regular audits in place which were carried out on daily, weekly and monthly intervals. However, we found some examples where issues had been identified through the audit process, but had not been acted upon. We also found that audits were not always carried out with the correct timescales. We made a recommendation about this.

Staff understood the needs of the people they supported and worked well with external professionals to ensure people's needs were met. We found evidence that staff recognised and responded well to people's changing needs. People received effective nutritional care and were satisfied with the standard and variety of meals provided.

Staff were aware of their responsibility to protect people from abuse and improper treatment. There was a good system in place which enabled both the manager and provider to monitor adverse incidents, such as

accidents or safeguarding concerns so that any themes or trends could be identified and addressed.

We found an ongoing breach of Regulation 12(2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to the management of people's medicines. The action we told the provider to take can be seen at the back of this report.

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.

Good improvements had been made in relation to the management of people's medicines. However, further improvements were necessary to help ensure safer working practices.

Staff were aware of risks to people's safety and wellbeing and the measures required to keep them safe. However, more personalised information in people's care plans and PEEPs would further help to ensure they received safe care and support.

Staff were in general recruited in a safe manner and staffing levels were determined in accordance with the needs of people who used the service. However, we made a recommendation that the way in which staff are deployed across the service be reviewed to ensure all areas within the home have adequate staff cover at all times.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's rights to make decisions about their care and daily life were promoted because staff were working in accordance with the Mental Capacity Act. However, more detailed information regarding people's mental capacity and ability to consent were required in their care plans.

The assessment and management of people's nutritional needs was much improved which meant people's health and wellbeing had improved. People had good access to health care and the service worked well with external professionals to ensure people's health care needs were met.

Arrangements for staff training were much improved. Training was being delivered in a timely manner and the manager had a system in place to monitor the area. This helped ensure staff had the skills to provide safe and effective care. However, staff supervision and appraisal needed to be brought up to date.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Some people's privacy and dignity was not always promoted due to personal information about them being in view in their bedrooms or en-suites.

We received positive feedback from people who used the service who told us they were treated with kindness, dignity and respect.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

The majority of people felt they or their loved ones received person centred care and that the service communicated well with them. However, this was not the experience of everyone we spoke with.

Staff had a good understanding of people's needs and the care they required.

People felt able to raise concerns and that any concerns they did raise would be dealt with properly.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The systems for monitoring safety and quality across the service were much improved. However, these systems needed to be used more effectively to ensure potential improvements, when identified, were acted upon in a prompt manner.

Following a period of instability in terms of the management of the home, the new management team was now in place and committed to making improvements across the service.

The Old Vicarage Care 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 had taken action to make improvements following the last inspection, when the service was awarded an inadequate rating for the area of 'safe' and issued with a warning notice in relation to good governance.

The inspection took place on 8 & 13 October 2015 and was unannounced.

The inspection team consisted of three adult social care inspectors and a pharmacy inspector. We were also accompanied by 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. This expert-by experience had expertise in services for older people.

Prior to our visit, we reviewed all the information we held about the service, including notifications the provider had sent us about important things that had happened, such as accidents. We also looked at information we had received from other sources, such as the local authority and people who used the service.

We spoke with seven people who used the service during the inspection and four relatives. We also had discussions with two managers, the deputy manager and four care workers, the cook and activities co-ordinator.

We contacted twelve community professionals as part of the inspection and received feedback from five of them. We also contacted the local authority contracts team.

We closely examined the care records of seven people who used the service. This process is called pathway tracking and enables us to judge how well the service understands and plans to meet people's care needs

and manage any risks to people's health and wellbeing.

We looked at medicines records for nine people who used the service. We reviewed a variety of other records, including policies and procedures, safety and quality audits, four staff personnel and training files, records of accidents, complaints records, various service certificates and records relating to quality assurance.

The provider returned the completed Provider Information Return (PIR), within the requested timeframes. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we conducted a SOFI (Short Observational Focused Inspection) on the dementia care unit over lunch time. A SOFI helps us to understand the experiences of people who are not able to talk in detail with us.

Requires Improvement

Is the service safe?

Our findings

Following the last inspection of the service an inadequate rating was awarded for this domain. We identified a number of concerns in relation to how risks to people were assessed and managed, medicines management, infection control and the recruitment of staff. During this inspection we found improvements in each of these areas.

Following the last inspection of the service we had a number of concerns about the management of people's medicines. During this inspection we found that some good improvements had been made, but identified that some areas were still outstanding.

People who used the service and were able to comment on this area, told us they received their medicines on time. Relatives we spoke with also expressed satisfaction with this aspect of care. One person described how care staff were supporting their family member well, in partnership with health care professionals, through changes to their medication regime.

We checked the medicines and records for nine people who used the service. We spoke with the manager, the deputy manager and a manager from the organisation. We noted improvements had been made to people's medicine records. We found all the records we looked at had photographs and any allergies a person had were recorded. This reduced the risk of medicines being given to the wrong person or to someone with an allergy.

Information regarding any medicines prescribed on an 'as required' basis was present in people's care plans. This helped ensure people would be offered their medicines when they needed them.

We found that the arrangements for the storage of medicines was improved. Controlled drugs (medicines that require special storage and record keeping arrangements because of their potential for misuse) were being stored safely. The current fridge temperatures were being recorded daily; however the minimum and maximum temperature was not. National guidance recommends that the maximum and minimum temperatures be recorded every day.

However, when viewing people's medicine records we found that medicines were not always given as prescribed by the doctor. One person did not have a medicine for their bowels for two days and their iron supplement for four days, as the home did not have the medicines in stock. A second and third person were taking a medicine for bone protection, which should have been taken once each week. Both of these people were given their medicine a day earlier than it should have been. A fourth person was taking two medicines to be taken an hour before food and one tablet to be taken after food, however all three medicines were given at the same time.

The quantities recorded for two medicines belonging to one person were different to what was in the home; this meant the medicines could not be fully accounted for.

These findings demonstrated a breach of Regulation 12(2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Everyone we spoke with told us they felt confident that they or their loved ones were cared for in a safe manner. People's comments included, "I've nothing to worry about, they look after you. They can't do enough for you." "They've looked after [name removed] really well". We asked people what made them feel safe and their answers included, "The kindness of the staff." I'm allowed to do what I want to do." And, "The way it's organised."

We found there was an improved range of risk assessments in place for each person who used the service. These covered a number of areas related to people's health care needs, such as choking, infection control, moving and handling, tissue viability and falling.

Where risk was identified, there was guidance for staff in how to maintain people's safety. We found in some examples, this guidance could have been more detailed and person centered. However, staff were observed following safe practice, for example, when assisting people to mobilise, and demonstrated a good understanding of the actions required to keep people safe during discussions with us.

We heard from a community professional who was complimentary about the way in which risks to the person they supported were managed. They told us, the person was at risk of falls and that staff managed this risk well, to ensure the person's safety and wellbeing was promoted.

We saw that smoking risk assessments were in place for people who required them. At the time of the inspection, the manager was in the process of updating these in response to updated guidance about the risks of smoking and the use of some local preparations, such as certain emollients.

PEEPs (Personal Emergency Evacuation Plans) were in place for each person. These documents provided guidance for staff in relation to the assistance people would need to evacuate the building in the event of an emergency. We saw that every person who used the service had a PEEP in place and that a copy was maintained in a grab pack, which would be quickly available in the event of an emergency. However, we found that PEEPs could have been improved by including more individualised information about the person and their specific needs.

It is recommended that each person's PEEP and risk assessments are reviewed and updated to include more individualised information about the support they require to maintain their safety.

There was clear guidance for staff about how to protect people who used the service from abuse and improper treatment. This guidance included information for staff about the different sorts of abuse people may be at risk of, potential warning signs and instructions on the action to take if any concerns were identified.

All the staff we spoke with showed a good understanding of safeguarding procedures and were able to describe the correct actions to take if they were concerned that a person had been the victim of abuse. Records viewed confirmed that safeguarding training was provided to staff and regularly updated.

People we spoke with shared mixed views about staffing levels at the service. People's comments included, "They get short staffed sometimes, it could be anytime and then it's a bit hectic. I have to do a lot of waiting. It's all waiting, but I'm happy here." "They are on call if we need them." "I don't think there are enough staff, they don't employ enough. You have to wait to go to the loo." "I think they could do with more on a Sunday,

there's only three." When we asked one person if they felt there was anything the home could do better they said, "More staff and not be kept waiting."

A community professional we contacted commented that whilst they were generally satisfied with the standards at the home, they visited on one recent occasion and noted there was no staff member in the lounge with people. This information supported our own observations during the inspection. We noted that the communal areas did not always have a member of staff present, for observation purposes.

The service had a formal tool in place to assess staffing levels in line with the needs of people who used the service and rotas we viewed, demonstrated that staffing levels were consistently maintained in line with these assessments.

We discussed staffing levels with a senior manager from the organisation, who advised us that the day and night staffing structure was constantly reviewed. We were advised that the service was in the process of recruiting new staff and had been supported by additional staff from across the organisation while there were vacancies. We noted that agency staff were also employed to ensure the service was staffed to the levels assessed as being required. In light of some of the comments we received and our observations, it is recommended that the manner in which staff are deployed across the home is reviewed to ensure there is adequate cover at all times, in all areas.

We found that significant improvements had been made to the recruitment practices at the service. However, we also noted further improvements could be made. We viewed the personnel files of all the staff that had been recruited since our last inspection. We noted all staff members had been required to undergo a formal recruitment procedure.

Prospective employees had completed application forms and provided an employment history. They had been required to attend interviews so that their suitability for employment could be properly assessed. A variety of background checks had been completed for the new employees, which included a DBS (Disclosure and Barring Service) check, which would demonstrate if a person had any criminal convictions or had ever been barred from working with vulnerable people.

A recognised form of identification and written references had been sought, where possible from previous employers. However, on one of the personnel files we viewed, we noted that their written references had not been received until after they started work. This did not demonstrate that information had been gathered about the prospective employee's previous work performance before they started to work at the service. It is recommended that recruitment procedures are reviewed to ensure all checks are carried out prior to a person commencing employment.

Since the last inspection of the service, infection control procedures had been updated. We saw that staff were now issued with infection control guidance, although in some parts we felt the guidance could have been clearer. For example, in one part, the guidance stated staff should follow colour codes for materials and equipment, but there was no guidance as to what the colour code was.

We noted that PPE (Personal Protective Equipment) was available throughout the home and we also saw that hand gel was provided in several areas. An infection control audit had been carried out and a schedule was in place to ensure this was repeated at regular intervals. We were advised that a designated lead for the area of infection control had been appointed.

People we spoke with expressed satisfaction with the cleanliness of the service. Their comments included,

"You could eat off the floor." And "I think they keep it very nice and clean. It's a credit really." A community professional, who visited the home regularly, described significant improvements in the cleanliness of the home.

However, during the inspection we noted some areas appeared to be visibly unclean. These included a bathroom and toilet and equipment such as the bath hoist. We also found that some areas were malodorous.

We saw that there were cleaning schedules in place, but these were not fully completed and not always checked. We also noted that a senior manager when carrying out quality checks at the home several weeks earlier, had noted that, 'more attention to detail was required with cleaning standards.'

We discussed these findings with the newly appointed manager who advised us she was in the process of reviewing all cleaning schedules and processes for carrying out checks, so as to ensure all areas of the home and all equipment, were maintained to consistently clean and hygienic standards.

The service had a fire risk assessment in place. We saw that this was reviewed on a periodic basis by an external consultant and we were also able to confirm that fire safety recommendations made by the consultant were followed through.

There were processes in place to ensure that regular checks on equipment such as fire equipment, emergency lighting and call bells were carried out. Records confirmed that these checks were now carried out regularly and action taken as a result. A daily air flow mattress check had recently been implemented to ensure all air flow mattresses maintained good condition and the correct pressure, and new lifting equipment including hoists, had recently been purchased.

A variety of certificates were available to demonstrate that equipment and facilities such as the passenger lift were subject to regular checks and servicing. Environmental risk assessments and audits were conducted, but not always in accordance with the specified time scales. This was an issue the new manager had identified and planned to address immediately.

We noted a gate at the top of the stairs, which was secured by a magnetic catch. We felt this could easily be released by someone accidentally and could potentially present a risk of falling down the stairs. It is recommended that the provider re-assess the suitability of this piece of equipment, whilst taking into consideration the need to be able to evacuate people quickly in an emergency.

Requires Improvement

Is the service effective?

Our findings

The service was found to require improvement in this area following the last inspection carried out in October 2015. This was because we found that the service did not manage people's nutritional needs well or ensure they obtained valid consent before care was provided. We also identified concerns about staff training and support.

At this inspection we found the service had made some good improvements in relation to the assessment and management of people's nutritional needs.

We saw there were nutritional risk assessments in place for each person who used the service. Where it was determined a person was at risk, there were actions in place to support them to maintain their health and wellbeing.

We viewed the nutritional risk assessment for one person who had recently been ill. We noted that the changing needs of this person had been identified and taken into account when planning for their nutritional needs. One of the community professionals we spoke with told us, "My client appears to be offered a nutritional and balanced diet, with regular meals and fluids offered and encouraged throughout the day."

The nutritional assessment of one person showed a high risk of malnutrition. This person had been underweight and had a poor dietary intake. However, their records stated, 'She is at risk of malnutrition, but not enough to be referred to a dietician.' This was not the course of action we would expect. If someone is at any risk of malnutrition it is always enough to seek the advice of the relevant community professionals. However, records of the person's weight demonstrated they were now gaining weight gradually, which indicated they were receiving good nutritional support.

We viewed an audit of weights carried out at the service on a regular basis. These demonstrated that all those who lived at the home were either maintaining a stable weight or were gaining weight, where this was beneficial for the individual.

The majority of feedback we received about the food provided was complimentary. However two relatives reported a lack of drinking water in people's rooms. Everyone said they had enough to eat and nobody felt hungry or had to ask for a snack. People's comments included, "It's [the food] very nice." "It's a nice selection." "First class, I've been satisfied up to now." "I think there's too much bread, but they will make me an alternative." "He's not that enthralled about it, I don't know if he's been asked about an alternative, they just give it to him."

In discussion, the cook told us there was always an alternative menu for both lunch and evening meals. She advised us that she had changed the menus in the time she had worked at the home to more varied meals and those that would appeal to the people who used the service. She had used questionnaires to find out what residents wanted. She explained that she was well informed of people's nutritional needs and

preferences and was aware of any special diets people required.

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. The application procedures for this in care homes and hospitals are 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 were being met.

Some care workers we spoke with demonstrated a good understanding of the MCA and DoLS. Others were not as clear about the Act, but had sufficient understanding to recognise when further advice should be sought. Training records showed that the majority of staff had been provided with training in the area and all those who had not, had training arranged.

We asked people if care workers asked for their permission before carrying out care. The majority of people said this was the case. However, one person commented, "They just help me." Another said, "They take it for granted."

A community professional we contacted expressed satisfaction with this aspect of the service and told us, "Staff are aware of [name removed] DoLS authorisation, with an understanding of why a DoLS is necessary. They also appear to be aware of the conditions documented on her authorisation. Capacity assessments and best interest documentation is in place for interventions/restrictions."

Each person's care plan had several consent forms in place which covered areas, such as the taking of photographs, personal care, social and health care, care and treatment, nutrition and medication. The format used was very detailed, providing a good explanation of what consent entailed. However, in some examples it was not clear if the person who had signed the consent forms, where this was a family member, had the legal authority to do so.

The care file of another person contained all the relevant documentation to demonstrate that Lasting Power of Attorney (LPA) had been granted on behalf of the individual. This meant the LPA was able to make decisions on behalf of their relative and consent forms showed this to be the case.

Records were available to show that where appropriate, staff had made applications for DoLS authorisations to the relevant authority. This meant that people's rights under the MCA had been considered and upheld. We also saw some good examples of records of decisions that had been made on behalf of people who used the service and were unable to consent to a specific aspect of their care. We saw that best interest decision making had been carried out with the person, their representatives and other professionals where appropriate.

Mental capacity assessments had been completed but the information was not always retained in people's care files. In addition, we found that some mental capacity assessments were generic and did not relate to specific decisions.

It is recommended that clear information regarding the legal authority of people giving consent to care and the ability of people to consent to specific decisions is maintained on their care plans.

People told us staff understood their health care needs and confirmed they received support to access health care when they needed it. Everyone felt confident that care workers would arrange a visit from a health care professional if they were unwell.

When viewing people's care plans we saw that a wide range of community professionals were involved in the care and support of those who lived at The Old Vicarage. This helped to ensure their health care needs were being appropriately met.

A community professional told us that care staff acted in a timely manner when any health concerns were identified.

At the last inspection of the service we found that some mandatory training was out of date. Since that inspection the provider had undertaken a full training audit and developed an action plan to address this.

We viewed the service's training matrix which demonstrated that a number of courses had been delivered and any mandatory training still outstanding, was booked in. In addition, all care staff who did not hold national qualifications had been enrolled on courses to complete them.

We noted that a system had been implemented to ensure that all training could be monitored by the manager on an ongoing basis. This enabled her to identify when a staff member's training was due to be refreshed or if any staff member had not completed their programme.

Each member of staff had an individual training record and a range of training certificates were present on their staff file, including the Mental Capacity Act, health and safety, safeguarding adults, infection control, moving and handling, basic first aid, medication awareness and the Control of Substances Hazardous to Health (COSHH).

We looked at how staff were supported when they first started to work at the service. We found that they were provided with a range of information to help them understand their role and the practices of the home. These included job descriptions, specific to the role for which they were appointed and relevant policies and procedures.

An induction programme was present in the staff files we saw. The first day of induction comprised of a simple checklist, which covered areas of good communication, general routines, the layout of the home and meeting those who lived there, certain duties and activities of daily living. The second part of the induction form was more detailed. However, it was incomplete for one member of staff, although this person's records showed they had completed the nationally recognised care certificate. A formal review was conducted six weeks following employment and the first supervision session was held at eight weeks.

Supervision records were seen on staff files. However, they were not conducted at regular intervals. For example these were a year apart for one person whose personnel record we examined and annual appraisals were a little overdue. The new manager of the home had identified this and told us that bringing supervisions up to date for all staff was one of her priorities.

Comments we received from people about the staff at the home were complimentary and people expressed satisfaction with the care they received. One person commented, "I am happy with them all [the staff]. I

think they are good at what they do and they care." "Some of them are excellent."

People also felt that the consistency of staff had improved and that there were less agency staff than we had found previously. Comments included, "They are usually regulars during the day." And, "More or less, it's the same staff."

Requires Improvement

Is the service caring?

Our findings

We spoke with people who used the service and their families about their experience of living at the home. We asked people if they felt that staff were kind and caring towards them. We received positive feedback and people spoke highly of care workers. Their comments included, "They know me well, they love me." "They're always there to listen if you're not happy." "Some of them are very kind and talk nice to me, they understand me." "They're very nice and helpful really, kind." "Very helpful, amenable, can't do enough for you." And "They're very good. I like them. I've found them very friendly."

People were generally satisfied with the way their care was provided. One person commented, "I think it's good, I couldn't find anywhere more suitable." Another told us, "I don't have to wait long, they're always there if needed." However, one person commented, "I think most of them are OK, when they have a lot on they miss things. If we ask them they attend to it. Sometimes we come and he's not been shaved, or he's not ready to go out."

We observed staff providing support and interacting with people who used the service. These observations were positive and we saw that care workers approached people in a kind and respectful manner.

We noted care workers responded to people's requests for assistance straight away and supported people with patience. They took time to explain to people what was happening, support them at their own pace and listen to them.

We heard one carer conversing with a person who didn't want to come out of their room or have anything to eat. We heard them gently encourage the person and see if there was something they could tempt them with. The person agreed to have some jam on toast and a cup of tea and then decided to come out of their room to the lounge.

People told us they felt their privacy and dignity was respected. Care workers were able to give us examples of how they ensured this was the case in day to day practice. For example, by knocking on people's doors and providing personal care in a sensitive manner.

However, during a tour of the home we noted that there was personal information posted in some people's bedrooms or en-suite bathrooms. In some examples, this included information about their use of continence products. The manager agreed to remove this information immediately.

Records showed that a key worker system was in place, which meant that each member of care staff was allocated a number of people to support. However, this arrangement was not to the exclusion of others, who lived at the home. This helped staff members to get to know a small number of people very well and therefore develop a good working relationship with them and their families.

We saw some good examples of important information in people's care plans about their personal preferences and wishes and how they might express these choices on a day to day basis. This helped care

workers to support people to make decisions and exercise autonomy. One person who used the service had been enabled to bring their pet dog with them and was supported to take care of him by staff. They told us that for them, this was the best thing about the home.

There was no restriction on visiting. Every person we spoke with told us they were free to receive visitors and could see them in private if they so wished. Visitors told us they could come at any time and were always made welcome.

An advocate is an independent person who will support people who use services to make decisions and express their opinions. We saw that there was information posted about local advocacy services in the communal area of the home. In addition, several people who used the service had support from local advocacy services. We were able to confirm that this had been facilitated by staff at the home who had referred people who used the service to the advocacy services.

Requires Improvement

Is the service responsive?

Our findings

People we spoke with told us they felt the service met their needs. People's comments included, "I do like living here. It is lovely. I have no complaints thankfully." "It's comfortable and the food's excellent." And "It's clean and friendly and if we ask, they are helpful."

We also received positive comments from community professionals we contacted. These included, "I believe the staff deliver good quality care." And "[name removed] appears settled and well cared for. Staff appear to have a good knowledge of her support needs. I have previously worked with other individuals at The Old Vicarage, all of their care also appeared to be person centred and appropriate to their needs."

At the last inspection of the service we had concerns about assessment and care planning procedures. We found that staff didn't always have a good amount of information about people's needs, particularly those staying at the home on a short term basis.

At this inspection we found that a pre-admission assessment had been carried out for each person who used the service. This helped the staff team to be confident they could provide the care and support needed by everyone who wished to live at the home.

Care plans had been developed from the information gathered at the pre-admission assessment stage. We found these to be detailed and in general, person centred, providing staff with clear guidance about people's assessed needs and how these were to be best met.

The care files we saw were well organised, making information easy to find. This meant that staff could locate what they needed to know quickly. There were individual profiles in the front of each file entitled, 'My Day'. These were person centred documents, providing staff with good information about people's preferences, their likes and dislikes and what they liked to do.

Records showed that the plans of care had been generated with the involvement of the person who lived at the home or their relative, if appropriate. The care plans included a signed agreement, which indicated that people would be given the opportunity to attend reviews of their care or that of their loved one, with their key worker every six months. The plans of care had been reviewed on a regular basis and any changes in need had been recorded well. This helped the staff team to keep up to date with any alterations of individual circumstances.

Each person's care plan we viewed contained a well detailed social profile. This contained some good person centred information, such as people's previous employment, important relationships, significant life events and preferred hobbies.

Care workers demonstrated a good understanding of people's needs and the support they required. A community professional commented, "[Name removed]'s care plans and risk assessments appear to be person centred, after having been recently updated and are reviewed on a monthly basis." The professional

also commented that care staff were aware of how to support the person safely and effectively.

The majority of people we spoke with felt their or their loved one's care met their needs and that their daily preferences were known and respected by staff. However, one person told us they felt their relative did not always get a choice about what to wear because she sometimes complained about what she was wearing. Another person also felt that their relative's personal care in relation to their dentures and bathing was not always provided in accordance with their wishes.

We noted in people's care plans that there were records of involvement of the person or their representatives, where appropriate. However, in discussion people did not recall any formal involvement. One person told us they felt communication could be improved, although in some care plans we saw records of detailed communication with families.

It was apparent that whilst most people reported good experiences in relation to person centred care, involvement and communication, this was not the consistent experience of all those who used the service. As such, it is recommended that the negative comments we received be explored, with an aim to ensuring that best practice is consistently applied across the service.

There was an activities coordinator employed at the home on a full time basis. We spoke with them about the arrangements in place at the service. They described a variety of activities which took part in the home and local community.

We were advised that regular activities included crafts, flower arranging, music sessions and quizzes. On the day of the inspection some people took part in a bowling session and others enjoyed a gardening club. Some people were watching a musical which we were told was a favourite. We were told that activities were arranged during the day and that the activity coordinator spent individual time with those people who preferred to stay in their rooms.

We were advised that people took trips out of the home on a 1-1 or small group basis. In addition, we saw that entertainers and visitors from the local primary school and brownies for example, also visited the home regularly.

We spoke with people who used the service about the activities provided. One person said, "I like the musical things, the man playing the accordion and karaoke." Another told us, "I go out for a walk every day and I play pool every day." Another comment we received was, "Sometimes they organise different things and I like to join in, it's a change from the TV. I like name that tune and guess the flowers."

A community professional told us, "My client is offered and participates in the many and varied social and stimulating activities. As far as I am aware an activity coordinator is on duty every weekday. Trips into the community are offered."

We looked at how people who used the service and their families were involved in the running of the home. We received mixed responses when we asked people about residents' meetings and taking part in satisfaction surveys. Some people told us they were aware the service held residents' meetings but none of them had attended. Only one of the people we spoke with recalled being asked for any formal feedback by way of a satisfaction questionnaire.

However, everyone we spoke with told us they felt able to approach staff if they wished to discuss anything or raise any concerns. People's comments included,

"If I don't like anything I just tell them." "I'd tell [name of care worker]. She's our spokesman." "I'd go to the manager."

We saw there was a written complaints procedure posted in the communal area of the home. This provided guidance for people on how to raise concerns and what they could expect in this event. Only one of the people we spoke with had made a complaint. They told us they felt this had been dealt with satisfactorily.

Requires Improvement

Is the service well-led?

Our findings

During the last inspection of the service we found that the provider did not have adequate arrangements in place to monitor the safety and quality of the service. The provider sent us an action plan within requested timescales stating how they would address the concerns raised.

The service had experienced some instability in terms of the management team. At the time of the inspection, the service had been without a registered manager for several months. In addition, the deputy manager had been on a period of extended leave for one year and the regional manager had recently left the organisation.

The provider was able to demonstrate they had made significant efforts to recruit a new manager who would be expected to apply for registration with the commission. This had taken several months but at the time of the inspection, the new manager had taken up her post and was completing her induction.

We saw that the provider had made arrangements for the service to be supported from other managers across the organisation in the absence of its own registered manager. There had been a number of changes to these arrangements over time, but the service had been in receipt of appropriate management cover at all times.

People we spoke with who used the service were aware there had been some management changes but were not fully sure of them. One person commented that they were aware there was a new manager in post, but they had not yet met them.

We received positive feedback from community professionals we spoke with about what they described as improvements in the service since the last inspection. One person commented, "The Old Vicarage has greatly improved to what I feel had become a tired care home. I feel it has now become a pleasant place to visit." And another said, "There seems to be some good improvement. The home is cleaner and the atmosphere has much improved."

There were mixed responses when we asked people who used the service and their families if they thought the home was well run. People's comments included, "Yes, but it's never going to be easy." "Definitely it is." "It is now." And "It's just having to wait a long time to get dressed in the morning, it seems a long time."

Staff expressed satisfaction with the management of the home and also commented on what they believed were improvements. One care worker said, "There has been lots of improvement since the deputy returned. We just need a proper permanent management structure now." Another told us, "There is a nice atmosphere in the home. The choice for meals has improved. We have a great staff team here."

We spoke with the new manager and the deputy manager during the inspection. They demonstrated a good understanding of the improvements required and were able to discuss the plans they had in place to achieve them. They also reported a good level of support from the provider.

There were a range of audits and quality checks in place. These included a monthly audit which was carried out by a senior manager from the organisation. We viewed recent records of these audits and noted they covered a variety of areas including the environment and aspects of care and support such as care planning. We also noted that various issues had been identified in the audits and recorded. However, action had not always been taken to address them. For example, the senior manager had identified in the March monthly audit that the home required a deep clean. This had not been acted upon.

Other processes for assessing quality included a tool called 'Walking the floor.' This was a range of quality and safety checks which were designed to be carried out on a weekly basis. The tool was a useful one which would assist in identifying and addressing areas for improvement quickly. However, it had not been completed regularly for some time.

Whilst it was recognised that the service had made a number of significant improvements since the last inspection, more effective use of audit tools would help ensure these improvements were maintained and further improvements made. As such, it is recommended that the full range of audit and quality assurance tools in place at the service are utilised effectively.

There was a system in place to record and monitor any adverse incidents, accidents or complaints that occurred within the home. This included a process for trend analysis which would help identify any themes that could indicate a particular area for improvement. In addition, we saw that records of adverse incidents and action taken as a result, were also monitored by senior managers from the organisation.

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 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had failed to ensure that adequate arrangements were in place for the safe management of medicines. 12(1)(2)(g)