Mr & Mrs R Miles

The Old Vicarage

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
The Old Vicarage is a residential care home providing personal care to for up to 10 people adults with learning disabilities or autistic spectrum disorder. At this inspection there were nine people accommodated and receiving personal care. The home is one adapated building over two floors, with an accessible external garden and car parking. Bedrooms are mostly single accommodation, with one shared double occupancy room. Communal lounge, dining, bathing and toilet facilities are also provided.

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

The registered persons had failed to operate effective governance systems, to consistently ensure the quality and safety of people's care and timely improvement when needed. Management audits, risk assessments and safe systems checks were not consistently operated or ensured.

Accurate and complete records, were not always maintained for the quality and safety of people's care, related decision making or in relation to person's employed and the management of the regulated activity.

Formal systems were not operated, to seek and act on feedback from relevant persons, on the service provided at The Old Vicarage for the purposes of continually evaluating and improving such services. Effective partnership working with local authority care comissiones was not consistently ensured for people's care and best interests.

Staffing arrangements were not always effectively determined or ensured. Systems for staff induction, deployment, supervision and relevant competency checks, were not always fully ensured or effectively determined, against nationally recognised practice guidance for people's care. Staff training updates were not always proactively ensured in a timely manner. Management remedial actions for staff training updates had been recently identified and agreed by external commissioning partners with the registered manager. Consultation had commenced with local authority care commissioners to review and agree additional staffing, to support people's increased access local community services of their choice.

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.

Based on our review of whether the service was safe and well led, the service was not able to demonstrate how they were meeting some of the underpinning principles of right support, right care, right culture. This was because the model and purpose of care and related staffing arrangements were not reviewed or fully identified against the principles, to ensure they were being met.

We found people's choice, independence and rights were not always fully ensured or effectively maximised in line with the principles, for people's access and participation in activities they enjoyed or aspired to, within their local community. Otherwise, people were often supported to have choice and control of their lives and staff often supported them in the least restrictive way possible, in their best interests. However, the policies and systems in the service did not always fully ensure this.

We were mostly assured of the provider's arrangements for the prevention and control of infection, including for COVID-19. However, the provider's management checks to fully ensure this, were not effectively operated to fully ensure continuous safe practice. People's medicines were now overall safely managed. People received their medicines when they should.

People told us they felt safe and were happy living at the service. Relatives were also satisfied with the management of the service and the care provided. All spoke positively about the manager and staff, who they said were approachable kind, caring and supportive.

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 December 2018).

Why we inspected
We received concerns in relation to the management of medicines, staffing, governance and record keeping at the service. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No further areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

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.

The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the Safe and Well Led sections of this full report.

You can see what action we have asked the provider to take at the end 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 are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment and good governance at this inspection. Please see the action we have told the provider to take at the end of this report.
Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not consistently 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 Care Act 2014.

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.

The inspection team
The inspection was carried out by a single inspector

Service and service type
The Old Vicarage is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the personal care provided, and both were looked at during this inspection.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we received about the service since the last inspection. This included any written notifications the provider sent us, about important events when they happened at the service and the provider's information return. This is information providers are required to send us to tell us about their service, what they do well and any improvements they plan to make. This helps us to plan and to supports our inspections. We also spoke with local authority care commissioners involved in people's care at the service.

We used all of this information to plan our inspection.

During the inspection
At our visit on 11 October we spoke with five people about their experience of the care provided. We spoke with the registered manager and two care staff, including the deputy manager. We also spoke with a representative of the registered provider [partnership]. We looked at three people's care plan records, medicines records and some records relating to the management and staffing of the service. This included staff recruitment, equipment servicing and maintenance, cleaning schedules and auditing systems.

After the inspection
On the 15 and 18 October we spoke with five relatives and two staff by telephone. We also continued to seek clarification from the provider to validate evidence found. The provider sent us some of the documents we asked for, relating to the management and staffing of the service.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question had deteriorated to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

● Risks were not always effectively, identified or managed for people's safety.

● We found gaps in some people's care plans where risks associated with their individual health conditions and independent use of electrical equipment had not been considered for their care. This meant their related safety needs were not effectively informed or fully ensured.

● There was no formal management system in place, for the routine monitoring and analysis of any health incidents that may occur within the service. Incident reporting forms were not provided for recording the occurrence of any individual safety incidents. This meant that any trends or patterns could not be reliably established when needed, to help accurately inform people's safety needs.

● There was an up to date comprehensive service risk assessment and related business contingency plan in place. However, this was not always followed to ensure regular fire drills and people's safe evacuation when needed, such as in the event of the fire.

The registered persons had failed to consistently ensure that people were protected from the risk of harm. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● Arrangements were in place for the regular servicing and maintenance of equipment used for people's care at the service. The record from the most recent safety inspection of the fire alarm system showed this was not up to current standard. We discussed our findings with a representative of the provider, who assured us they would take the action needed, to rectify this for people's safety. Following the inspection, they provided documentary evidence of remedial work booked and due to commence.

● A range of individual risk assessments were routinely undertaken and regularly reviewed to inform people's individual safety needs. This included risks from falls, malnutrition, bathing/scalds, personal behaviours and to ensure safe community access.

Staffing and recruitment
● Staffing arrangements were mostly sufficient.
● Action was now in progress to agree funding for additional staff hours with local authority care

commissioners. So as, to maximise people's lifestyle preferences and personal development opportunities following the closure of local day care facilities, which people had previously regularly enjoyed access to.

● Otherwise, staff, relatives and people living at the service felt there were generally enough staff to provide people's care and support. One person said, "Staff are here [always], if I need help; they help me go shopping." A relative told us, "Staff are always present, helpful and supportive, but the main issue now the day care service has gone, is to get people back out there doing more things they like."

● During the inspection we saw staff were visible, responsive and provided people's care and support in a timely manner when needed. For example, supporting people's emotional and nutritional needs and their preferred daily living routines.
● Staff told us, and records showed, the provider carried out a range of required pre-employment screening checks, to help ensure staff were safe to work with vulnerable adults within the service. This included staff interviews, individual health declarations, checks of training and experience and checks though the national vetting and barring scheme.
●We found some gaps in two out of six staff recruitment records we looked at, where dates of previous employment were not fully demonstrated, so that any gaps could be explored before the decision to offer employment was made. Additionally, an employment reference obtained for another staff member, did not confirm the role and capacity of the referee as stated by the staff member on their job application form. The registered manager told us they would take the remedial action needed, to rectify this.

Using medicines safely
● People's medicines were safely stored and accurately recorded. We saw staff giving people's medicines safely, at the time people needed them and in the way they preferred.

● Action had been taken following the local authority's recent quality monitoring report of the service. To ensure accurate record keeping for any skin prescribed and completion of overdue medicines training updates in line with the provider's policy guidance for medicines safety.
● Staff responsible for people's medicines told us how they were competency checked through observed practice by the deputy manager. To ensure they understood how to give medicines safely, before they did so. However, there were no recorded individual staff competency assessments to show this. The registered manager told us they had no knowledge of how to obtain or use any suitable format for the assessment and recording of staff medicines competency. We therefore signposted them to relevant nationally recognised guidance for this, which they agreed to follow.
● Regular management audits of people's medicines were not routinely carried out, to continuously ensure the safe administration and accurate record keeping of people's medicines. We have referred further to this under the Well Led section of the report.

Preventing and controlling infection
● We were assured regarding the provider's arrangements for the prevention and control of infection, in relation to shielding and social distancing, admissions, use of PPE, testing access, staff vaccinations and universal principle for cleanliness and hygiene.
● The home was visibly clean and cleaning schedules showed the regular cleaning of the environment. However, the correct type and use of cleaning product for any decontamination associated with COVID-19, was not fully understood. We discussed this with the registered manager who agreed to take the action needed to rectify this for people's safety, when needed.

● The provider's own management auditing system, to regularly check whether the arrangements for infection prevention and control within the service were safely ensured were not being followed. There had been no related management audits undertaken or recorded, since February 2020. We have referred to this further under the Well Led section of this report.

Systems and processes to safeguard people from the risk of abuse
● Safeguarding arrangements were effective.
● Staff understood how to recognise and respond to any suspected or witnessed abuse within the service. The provider's related training arrangements and policy guidance helped to ensure this.

● People said they felt safe living at the service and were confident and knew who to speak with if they didn't. One person said, "I'm happy and safe – yes I am." Another person said, "I tell [staff names}; It's nice here, I like it."

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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated 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; Continuous learning and improving care; Working in partnership; Engaging and involving people, the public and staff.

● The registered persons did not have a coherent governance policy or related management strategy, for the effective oversight and management of the service. This meant the quality and safety of people's care was not effectively ensured, including to ensure timely service improvements when needed.

● The registered persons did not ensure regular management audits to check the quality and safety of people's care were not routinely carried out. The registered manager showed us a standardised audit for, which they said they used for the prevention and control of infection at the service. An audit process was incorporated for COVID-19. However, this was last completed and dated February 2020. The manager was not able to provide any other audits relating to people's care and safety.

● We found a range of concerns at this inspection, where improvement actions needed for the quality and safety of people's care, had not been proactively identified, planned or acted on by the registered persons. This included areas relating to staffing, medicines, risk assessment measures and best interest decision making. Accurate and complete records were not always fully ensured, to effectively account for people's care and safety, and the management and running of the service.

● Care practice and service provision was not always checked against nationally recognised or statutory guidance concerned with the quality and safety of people's care. For example, to ensure staff competence for safe medicines administration; effective care induction standards for staff and the right care, support and culture for people living with a learning disability or autism.

● The registered manager was unable to locate a statement of purpose for the service. They advised this had not been reviewed from the original version more than 15 years ago. This indicated a lack of ongoing review of service provision, to ensure it met with current guidance and requirements for people's care

● Formal systems were not effectively operated, to seek and act on feedback from relevant persons on the service provided at The Old Vicarage, to help inform or improve people's care when needed. For example, staff and resident meetings had not been held since February 2020. There were no alternative formal mechanisms used to obtain people's views or those of their relatives, to inform service planning and improvement, to enhance people's care experience.

● The local authority care commissioner's quality monitoring report from their visit to the service in

September 2021, showed the registered persons had not provided the local authority with a quality return for the last three quarters of a year to help benefit people's care experience. That report also identified a range of service improvements needed for people's care. There was no identified management improvement strategy in place to show how and by when this would be addressed. This showed a lack of effective partnership working.

People were at risk of receiving unsafe or ineffective care that often, lacked accountability. This was because the registered persons had failed to operate effective governance and management systems, to consistently ensure the quality and safety of people's care and timely service improvement when needed.
This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people.
● Accessible information had not been fully considered maximise people's understanding in relation to their care arrangements.
● Good care outcomes were not always ensured for people, in timely manner. For example, following the closure of a day centre which people had regularly accessed. To enable them to participate in alternative similar or new activities of their choice; or to meet with others who hold similar interests to themselves.

● People said they were overall happy living at the service and relatives were generally happy with the care provided. All spoke positively overall about the management of the service and felt the manager and staff were approachable kind, caring and supportive. Some people told us about how they were consulted and supported with aspects of their care and daily living arrangements, for their independence and autonomy. For example, choice of where and how to spend their time at the service. One person told us they were particularly happy with the support they'd received from the registered manager, to attend a family wedding and shop for their outfit to wear. However, some people and relatives felt access to relevant community facilities for people living with learning disabilities, needed to be improved.
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 was aware of the need to notify CQC of any important events that occurred in the service. For example, any safeguarding or significant health incidents.

● The most recent inspection rating was displayed, as required to do so.

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 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act (Regulated Activities) Regulations 2014. Risks were not always effectively identified or managed for people's safety.

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 17 HSCA RA Regulations 2014 Good governance The registered persons had failed to operate effective governance and management systems, to consistently ensure the quality and safety of people's care, incllluding timely improvements when needed. This was a breach of Regulation 17, section (1) (2), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We issued the registered persons a warning notice. For failure to comply with the relevant requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. If the registered persons fail to achieve compliance with the relevant requirement within the given timescale, we may take further action.