Care Quality Commission

Astoria Healthcare Limited

Vicarage Farm Nursing Home

Inspection report

139 Vicarage Farm Road
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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

About the service
Vicarage Farm Nursing Home is a care home with nursing for up to 59 older people. The home provides care for people who are living with dementia, other nursing needs and people who are nearing the end of their lives. At the time of our inspection, 58 people were living at the service.

People's experience of using this service and what we found
The staff did not always assess accidents and incidents. They did not identify if there were specific triggers for these adverse events and therefore did not learn how to make improvements to prevent further incidents.

Not all the risks to people's safety and wellbeing had been identified, assessed or managed. This meant there was a potential risk of people being harmed.

Some records used to describe people's needs and how they had been cared for were not complete and did not provide enough information about their care and safety.

We discussed these areas of concern with the registered manager and management team. They agreed to look at how they could make improvements in these areas.

People using the service were happy with the care they received. The staff were kind, polite and knew them well. They were provided with personalised care which reflected their preferences and met their needs. This was particularly evident in the range of different activities and social events.

There were procedures designed to help make sure staff were suitable and had the skills and knowledge they needed. These procedures included checks during recruitment, regular training and supervision. The staff told us they felt well supported and were happy working at the service.

People received their medicines in a safe way and as prescribed.

There were suitable systems for managing infection prevention and control. The staff were aware of these and the systems had been reviewed and updated since the start of the COVID-19 pandemic.

The registered manager was suitably qualified and experienced. They worked alongside a team of senior staff and they all knew the service well. There were appropriate systems for reviewing people's health and working with others to make improvements regarding this.

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

Rating at last inspection

The rating at the last inspection was good (published 2 June 2018).

Why we inspected
The inspection was prompted in part due to concerns received about unexplained injuries, complaints about the service and whistle blowing alerts. As a result, we undertook a focused inspection to review the key questions of safe, responsive and well-led only.

We have found evidence that the provider needed to make improvements. 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.

We reviewed the information we held about the service. No 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.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Vicarage Farm Nursing Home 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 governance at this inspection.

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

Follow up
We will request an action plan for 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? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service responsive? The service was responsive. Details are in our responsive findings below.	**Good**
Is the service well-led? The service was not always well-led. Details are in our well-led findings below.	**Requires Improvement**

Care Quality Commission

Vicarage Farm Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was conducted by two inspectors, a nurse specialist advisor and a member of the CQC medicines team. An Expert by Experience did not visit the service, however they made telephone calls to some of the relatives of people who used the service. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Vicarage Farm Nursing Home 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 care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. 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
This inspection was unannounced.

What we did before the inspection
We looked at all the information we held about the provider. This included information received from the local authority, complaints and information from the provider about significant events, such as safeguarding

alerts, accidents and incidents.

During the inspection
We spoke with five people who used the service and a visiting relative. We carried out observations to see how people were being cared for and supported. Our observations included the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with staff on duty who included four care workers, two nurses, an activities coordinator, the deputy manager, quality assurance manager, support manager, registered manager and one of the company directors.

We looked at the care records for five people who used the service. We looked at records of complaints, accidents, incidents, meeting minutes, quality audits and the recruitment, training and support records for six members of staff.

We conducted a partial tour of the environment, in particular looking at how infection prevention and control was managed and we looked at how medicines were being managed.

After the inspection
We continued to contact relatives of people who used the service for their feedback. We spoke with a total of six relatives over the telephone.

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 has now 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.

Learning lessons when things go wrong

- The systems for learning when things went wrong were not always operated effectively. The staff completed reports of incidents and accidents, but these reports were incomplete and did not include information about triggers and why the incident had happened. For example, the reasons recorded for the majority of incidents were ''dementia and challenging behaviour.'' These did not describe what had happened to cause the specific incident. Therefore, there was no analysis to identify what measures needed to be put in place to reduce the risk of them happening again.
- Some people were provided with individual support throughout the day and night. Despite this, there had been incidents where these people had fallen or been involved in an incident of aggression. The provider's reports did not show that there had been any investigation into the reasons why the person might be behaving in this way and if there was anything the staff could learn from this. For example, when people were agitated and refusing care, they had not analysed what the reason for this was other than this was a ''known behaviour''. Therefore, they could not analyse whether they needed to change their care approach or support the person in a different way.
- The staff used forms for tracking what happened before, during and after an incident. However, they were not completing these with all the necessary details. Instead of recording the time of an incident, they had only recorded whether the incident took place during the day or night. This meant they were not able to identify if a person's agitation was related to a specific time. The recording of what had happened was not detailed enough to capture all the elements which could have contributed to the incident. There was no analysis of completed forms to identify patterns. This meant the records were not used to evaluate whether people's planned care was meeting their needs.
- The records of incidents did not always show staff had considered the person's perspective. This sometimes meant that no further investigation into what had happened took place. For example, one incident record stated a person told staff they had abdominal pain and were going to collapse. The record went on to state they ''threw'' themselves onto the floor. The recorded cause for this was, ''challenging behaviour due to cognitive impairment.'' There was no recognition that the person had expressed pain and the reason for their collapse may have been because of this. The way the report was worded indicated the staff member believed this to have been a deliberate act. Therefore, there was no further investigation into the cause of the person's pain and discomfort.
- In another incident record where a person was found to be smoking inside their bedroom, the staff stated the person was ''caught red handed.'' The report went on to state they removed the person's cigarettes and the person then tried to take the staff member's electronic tablet. The recorded reason for this was, ''[Mental health condition] and habit.'' There was no indication the staff had considered how this situation may have felt to the person using the service. The staff member went on to write a message to the deputy manager

stating, ''please sort this problem out.'' There was no recognition of the person's feelings and needs or how they could be supported.

Failure to assess and mitigate the risks of providing care and treatment to people placed them at risk of harm. This was a breach of Regulation 12 (safe and care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

● The provider had failed to monitor and manage all risks to people using the service. The nurse responsible for supporting people in one unit told us about a person who was at risk of falling over the rails attached to their bed. We observed their bed was set at the highest level and bed rails were in place. The bed mechanism was broken, and the bed could not be lowered. This had not been reported to the nurse in charge or the home's maintenance team. None of the staff were able to explain when the mechanism had broken. This placed the person at increased risk of injury from a fall.
● A falls risk assessment for this person stated the risk of falling was severe and the likelihood probable. The assessment also recorded that they tended to crawl on the floor. A bed rails assessment for the same person did not evaluate whether the person was at increased risk of climbing or falling over the top of their bed rails. Therefore, the provider had not fully assessed or monitored the risks relating to falling from bed.
● Two relatives of other people expressed concerns to us that their relatives had fallen at the service. One relative told us this was because the person had climbed out of bed. Records showed this person had fallen three times during the night and once during the day since September 2020, on two occasions they were found on the floor having previously been in bed. The actions for minimising further falls were recorded as ''monitor closely'', ''maintain challenging behaviour chart'' and ''crash mat in place.'' Whilst the crash mat may help prevent injury, the other measures had not helped reduce this person's risk of falling.
● The staff had assessed the risk of another person's aggression. There had been three incidents in August 2020 when the person hit and/or scratched other people using the service. Their risk management plan had not been changed or updated following these. Observations made about this person did not include any analysis of when they displayed increased aggression or whether staff interventions had any impact on preventing incidents. Therefore, the staff were not monitoring this risk or taking sufficient steps to mitigate this.

Failure to assess and take steps to prevent or minimise the risk of falling and other incidents placed people at risk of harm and was a further breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the registered manager explained they had made referrals for people to a multidisciplinary falls clinic and they were waiting for further guidance about how they could support these people. They had also made a referral in respect of the person who had displayed aggression towards others.
● The staff assessed risks associated with people's physical wellbeing, skin integrity and nutrition. These assessments were evaluated monthly. We saw there were effective systems for monitoring people's health conditions including close work with other healthcare professionals. People received the care they needed to maintain healthy skin and prevent pressure areas. Staff recorded interventions and responded when people's health and weight changed.
● There were checks on the safety of the environment and fire safety, including training for staff about how to evacuate people safely and individual evacuation plans for each person.

Systems and processes to safeguard people from the risk of abuse

● People using the service told us they felt safe. One person said, ''Definitely, no better place to be'' and another person told us, ''I have never seen anyone badly treated.'' Relatives also felt people were safely cared for. Their comments included, ''I feel [person] is safe because the staff understand [them]'' and ''The staff call me straight away if something happens.''
● The provider had procedures for dealing with safeguarding alerts and whistle blowing. The staff received training in these. The staff were able to tell us what they would do if they were concerned someone was being abused.
● The provider had responded appropriately when there had been allegations of abuse. They had worked with the local authority to investigate these.

Staffing and recruitment
● There were enough staff to keep people safe and meet their needs. People told us staff responded quickly when they needed care and support and they did not have to wait for care. We also observed this, with staff attending to people's needs promptly and answering call bells quickly.
● Most of the care was given by the provider's own staff. They rarely had to book additional agency (temporary external workers) staff and when they did, the registered manager assured us they used the same familiar staff who worked solely at the care home.
● There were systems to help make sure only suitable staff were recruited. These included pre-employment checks on their suitability, an induction into their role and assessments of their competencies.

Using medicines safely
● Medicines were safely managed. There were systems for ordering, administering and monitoring medicines. Staff were trained and deemed competent before they administered medicines. Medicines were safely secured, and records were appropriate.
● Observations of staff showed they supported people to take their medicines. The provider had a system in place to ensure where people needed support with their medicines this was received and managed in a safe way.
● Since the last inspection, the provider had introduced a new system to monitor and audit people's medicines on a regular basis, and we found improvements had been made as a result of this. For example, a dual audit by the manager and deputy manager was carried out periodically to ensure medicines were up to date and appropriate for people.
● Although the provider stated there had not been any medicines related incidents in the last 12 months, we were assured that should a medicines related incident occur, there were adequate processes in place to ensure staff learned from these incidents to prevent them occurring again. People received their medicines as prescribed, including Controlled Drugs and those on covert (without their knowledge) administration. We looked at 12 Medicines Administration Record (MAR) charts and found no unexplained omitted doses in the recording of medicines administered, which provided a level of assurance that clients were receiving their medicines safely, consistently and as prescribed.
● There were separate charts for people who had medicines such as patches, ointments and creams prescribed to them (such as pain relief patches), and these were filled in appropriately by nurses.

Preventing and controlling infection
● There were suitable systems for the prevention and control of infection. These had been reviewed and updated to reflect the risks associated with the COVID-19 pandemic. There were policies and procedures which the staff were aware of and had training in. Information about good infection control practices and hand hygiene was displayed throughout the home.
● The staff wore personal protective equipment (PPE) when providing care and at work. People confirmed this was always the case. There were supplies of this equipment, and people using the service were able to

wear masks or face guards if they wished. There were appropriate systems for disposing of PPE and other clinical waste.

● The environment was clean and hygienic. Housekeeping staff were employed and had a system for ensuring all areas were kept clean, including extra cleaning of touch and high-risk areas. The provider carried out regular infection control audits and created action plans where improvements were needed.

● Staff and people using the service were encouraged to have seasonal flu vaccinations. There was an appropriate regime for COVID-19 testing. The staff recorded any infections people experienced and monitored these. There were regular clinical meetings for senior staff and at these they discussed how infections were being prevented, managed and controlled.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people's needs were met through good organisation and delivery.

Improving care quality in response to complaints or concerns
● There was an appropriate procedure for investigating and responding to complaints. People and their relatives told us they knew who to speak with if they had any concerns.
● The provider recorded complaints and the action they had taken in relation to these. There was evidence of learning from these to improve the service. However, the provider had not always given timely feedback about their actions to people who raised concerns.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
● People's needs were met in a personalised way. People told us they were happy with the care they received. Their comments included, ''They are very nice here, they all understand us, they are very caring and always willing to help'' and ''They try their hardest to help people.'' Relatives also felt there was good care. One relative told us, ''[Person] is in good shape, [they] have thrived here, the staff are attentive and [person] is always clean and well looked after.''
● We saw people looked well with clean clothes, hair and nails. People had enough to eat and drink and staff encouraged them with these. The staff were available and attentive, and their interactions were kind, considerate and caring. People were encouraged to take part in activities and staff spent time talking with people who did not want to join with others.
● The staff recorded people's needs in care plans. Information was clearly presented and regularly reviewed. The staff kept a log of the care they provided, and this showed they were following people's care plans.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● The staff met people's communication needs. Care plans included information about any sensory, communication or language needs. There were plans to say how these would be met. The staff spoke a variety of languages and everybody living at the home had at least one member of staff who could speak their first language.
● Information about activities, meals and staff was displayed around the home and people were able to make informed choices. We saw the staff explaining options to people, for example when offering them meals.
Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● There was a range of different activities and social events for people living at the home. Whilst the COVID-19 pandemic had restricted some activities, such as trips out, the staff had worked hard to make sure there was still a good variety of activities and events for people to take part in.
● There was a team of activities coordinators and staff who planned and facilitated activities. Each day there was a programme of group events. These were varied and met people's interests and needs. The activity staff also provided individual support for people who r needed this. For example, reading, hand massage and playing board games. People spoke positively about activity provisions and told us there were themed activities to celebrate different events, such as saints' days, religious festivals and traditional celebrations like bonfire night.
● People's individual interests, religion and culture were respected, with meal options and opportunities for worship.
● At the time of the inspection, visits to the service were restricted because of COVID-19 and the national lockdown. However, the registered manager told us they were looking at different options to facilitate more visits. Relatives understood this and told us the provider was good at making sure people stayed in touch through video calls.

End of life care and support
● Some people were cared for at the end of their lives. The staff worked closely with palliative care teams and other professionals to make sure people were comfortable and pain free. They recorded people's wishes and preferences in care plans, so they knew how to support them at this time.
● There were no restrictions for the relatives and friends of people who were dying. The registered manager and staff recognised the importance of allowing people to be with their loved ones at this time. These visits were managed safely in line with the provider's infection control procedures.

Requires Improvement

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 requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Continuous learning and improving care
● The provider did not effectively operate systems to assess, monitor and mitigate risk. They had not always evaluated the risks of people falling. Where there had been incidents and accidents, such as falls, the staff had not analysed what had gone wrong and therefore they did not make the quality improvements needed to prevent these incidents happening again.
● Some records were not accurately completed. For example, one person's care plan stated their catheter needed to be changed every three months. Records showed this was last changed in January 2020. We looked at the care provided for this person and there was no indication of adverse effects on their health. Staff told us the catheter had been changed as per their plan, but records had not been updated to reflect this. There was a ''do not attempt resuscitation'' form in one person's care plan. There was no evidence the person or their representatives had been consulted regarding resuscitation decisions. The form had not been completed but provided a quick reference to show staff not to resuscitate this person in an emergency. This meant staff might wrongly withdraw life-saving care if the person needed it. The staff agreed this was incorrectly placed in the person's file and removed it after we discussed this with them.
● Risk assessments did not always accurately reflect how care should be provided for people. For example, the staff described interventions for one person which were not fully recorded in their care plan or risk management plan. This intervention was intended to reduce agitation, but the description of this within the plan lacked detail about how the staff should support the person. Additionally, the assessment for this person identified they posed a risk to others. However, the assessment did not describe who was at risk or under what circumstances people might be placed at risk. The staff were able to explain more details about this, however the records did not reflect this important information.

Failure to maintain accurate records and to effectively operate systems to mitigate risk and improve quality was a breach of Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had a range of audits which they and the staff undertook to monitor the quality of the service. These were detailed and included action plans when things needed to improve. The qualified staff had regular clinical meetings to discuss people's needs, such as their health, weight, skin condition and whether to respond to any changes in these.
● Records of care indicated people's health and wellbeing were well monitored. There had been improvements in their health and weight. When needed, the staff had liaised with other professionals to

help make sure people received care and treatment they required.

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 provider had a process for dealing with complaints and duty of candour. We saw that complaints had been investigated but the provider had not always responded to complainants or sincerely apologised when things went wrong. For example, one person had raised a concern in August 2020 about the wellbeing of their relative. The staff had looked into this, contacted relevant health professionals and made sure the person received the care they needed. However, they had not communicated this with the person's relative and did not update them until the person complained again six weeks later. The response they gave following this did not adequately apologise for what had happened or address some of the concerns the relative had raised. For example, they had said, ''we were left concerned and feeling [person's] health was unimportant, please let me know what measures have been put in place to prevent this happening again.'' The provider did not acknowledge or respond to these points.

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

- People using the service and their relatives told us there was a positive culture at the service. Some of their comments included, ''It is nice, the staff always seem to know people'' and ''It is very loving, the staff do not rush people and take their time to let people make choices.''
- We observed care being provided in a personalised way with staff empowering people to make decisions and to feel comfortable. The staff told us they felt supported and liked working at the service. The management team spoke highly of the staff, praising them for their work and dedication to the service.
- The provider kept a file of events and good work. This showed a range of different activities, including people learning independent living skills and taking part in social events. There was also evidence of the staff undertaking a range of relevant training which included hands on experience of being cared for.

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

- People using the service, their relatives and staff spoke positively about the registered manager and other members of the management team. The staff told us managers were always available to assist them and work alongside them when needed. There was a team of management staff undertaking different responsibilities for running the service.
- The registered manager was appropriately qualified and experienced. They had previously managed other care homes and had worked at the service for several years. They had a good knowledge of legislation and guidance regarding care provision. They kept the other staff and stakeholders updated with information about changes. For example, they shared information about the COVID-19 pandemic and the impact this had on the care home. There were regular meetings for all staff and for each department to keep updated with changes at the service.

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

- The provider involved people using the service and their relatives in reviewing their care. Relatives confirmed this telling us they were asked to contribute to care plans. They also said there was good communication, and this had continued since the outbreak of the pandemic by using phone and video calls to stay in touch.
- All stakeholders were asked to complete satisfaction surveys to discuss their experiences of the service. The provider had recently asked people to complete these and was in the process of analysing the

responses at the time of the inspection.
● The provider kept a log of compliments and feedback from people using the service and other stakeholders. This showed people felt involved and the feedback was generally positive. Some of the feedback showed the staff had forwarded photographs to relatives during lockdown when they could not see their loved ones, so they could view what they had been up to and see they were happy and well cared for.

Working in partnership with others
● The staff worked closely with other health and social care professionals and had made referrals for extra support when people needed this.
● The registered manager took part in forums and meetings with other care providers and the local authority to share ideas and keep updated with changes in guidance and legislation.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not always ensure care and treatment was provided in a safe way for service users. Regulation 12(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not always effectively operate systems and processes for assessing, monitoring and improving the quality of the service and assessing, monitoring and mitigating risks. Regulation 17(1)