Vicarage Care Limited

The Old Vicarage

Inspection report

Ireleth Road
Askam In Furness
Cumbria
LA16 7JD

Tel: 01229465189

Date of inspection visit:
25 January 2022

Date of publication:
23 February 2022

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
The Old Vicarage is a residential care home registered to provide accommodation and personal care for up to a maximum 30 older people. At the time of our inspection there were 26 people using the service.

People's experience of using this service and what we found
People told us they felt comfortable and happy living in the home. Whilst the environment had a satisfactory standard of cleanliness, the provider had failed to implement robust infection prevention and control measures. In both lounges, people who had tested positive for coronavirus were sat alongside people who had tested negative with no social distancing. This put people at high risk of being infected. Lateral flow test devices had been left on the desk in the office, some showing a positive result. In addition, we were not asked for evidence of a negative test or our vaccine status on entry into the home. The registered manager was not able to come to the home due to a period of self-isolation after testing positive for Covid-19. However, they gave the staff immediate instructions to address this situation over the telephone.

The staff confirmed they had completed training on safeguarding vulnerable adults. There was a safeguarding policy and procedure, available to all staff in an electronic format. On looking at records, we noted the provider had carried out an investigation following allegations of abuse; however, they had not reported the allegations to the local authority in line with safeguarding vulnerable adults' procedures. This meant the local authority had no oversight of the investigation.

Individual risks had been assessed and recorded as part of the electronic care planning system. However, environmental risk assessments had not always been carried out and there was no risk assessment seen to assess and manage an outbreak of coronavirus. The provider sent us a copy of the risk assessment after the inspection.

On a tour of the premises we noted instances of unfinished work. The visitors' pod had been removed for urgent drainage work; however, we were given assurances this would be reinstated the week after the inspection.

There were sufficient staff deployed to meet people's needs and we observed caring interactions throughout our visit. On looking at two staff files, we noted there were gaps in the recruitment records. The registered manager told us this issue would be addressed.

People and relatives were complimentary about the leadership and management of the home. Whilst the registered manager and provider sent us evidence of their checks, we found shortfalls during the inspection in several aspects of the service. People were consulted about their daily care; however, they had not been invited to complete a satisfaction survey during 2021 and there was evidence of only one residents' meeting in September 2021.

The provider and registered manager gave assurances they would make the necessary improvements to the service.

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

Rating at the last inspection
The last rating for this service was good (published 9 June 2018).

Why we inspected
We undertook a targeted inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about infection prevention and control practices and the management of the home. A decision was made for us to inspect and examine those risks.

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. This included checking the provider was meeting COVID-19 vaccination requirements.

We inspected and found there was a concern with infection prevention and control arrangements, so we widened the scope of the inspection to become a focused inspection which included the key questions of safe and well-led.

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 the provider needs to make improvement. Please see the safe and well-led sections of this full report.

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

Enforcement
We 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 the management of infection prevention and control and safeguarding allegations as well as the governance of the service.

You can see what action we have asked the provider to take at the end of this full 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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always 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.

Inspection team
The inspection was carried out by one 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. The Care Quality Commission (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 reviewed information we had received about the service, such as notifications. These are events that happen in the service that the provider is required to tell us about.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service

does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We observed how staff provided support for people to help us better understand their experiences of the care they received. We spoke with four people using the service, four members of staff, a housekeeper, the activities organiser and the administrator. The registered manager was unable to be in the home due to testing positive for coronavirus but was available throughout the inspection over the telephone. We also discussed the findings of the inspection with the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We conducted a tour of the premises with a member of staff. We also reviewed a range of records. This included four people's care records and risk assessments, medication records including the controlled drugs register and two staff members' recruitment records. A variety of records relating to the management of the service were also reviewed.

After the inspection
We continued to seek clarification from the provider to confirm evidence found. We spoke with four relatives over the telephone and requested additional information from the provider. The registered manager and provider submitted information and evidence of provider oversight.

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 good. At this inspection, this key question has 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.

How well are people protected by the prevention and control of infection?
Prior to the inspection visit, concerns were shared with us about some aspects of infection prevention and control practices in the home.

● Whilst the home had a satisfactory standard of cleanliness, people were placed at high risk of infection. On arrival in the home, we were not asked for proof of a negative Covid-19 test or our vaccine status. There were a number of Lateral Flow Device test strips lined up on the office desk with several showing a positive result. We were informed 12 people living in the home had currently tested positive for coronavirus.
● Although some people were isolating in their bedrooms, 16 people were sat in lounges. There was a mixture of people who had tested positive and people who had tested negative for coronavirus in both lounges, with no social distancing. The two toilets near the lounge areas had not been designated, so people were using either toilet irrespective of their Covid-19 status. This meant people without the virus were placed at very high risk of being infected.
● Staff were wearing personal protective equipment throughout the inspection. However, they were not seen wearing eye protection, when supporting people who had tested positive for coronavirus.
● On a tour of the premises, we found a yellow bin was outside a person's room, infected laundry was put in red bags and put in the bin outside the laundry rather than being left for 72 hours in the bedroom and not all bedrooms had notices on the doors to alert staff of the infection.
● During the inspection, there was no risk assessment seen to assess, mitigate and manage an outbreak of coronavirus.

The provider had failed to assess the risk of infection and put measures in place to prevent and control infection. This was a breach of Regulation 12 (1) (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager made immediate arrangements to address this situation during the inspection and sent us details of the actions they had taken following the inspection. The provider also sent us a copy of a Covid-19 risk assessment dated October 2021.

● During the inspection, we saw there was an infection prevention and control policy and an audit carried out in March 2021. However, following the inspection the registered manager informed us infection control audits were carried out in August 2021 and November 2021.

From 11 November 2021, registered persons must make sure all care home workers and other professionals

visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement. We found the service had measures in place, although these were not followed at the time of our visit.

● The registered manager informed us relatives were able to visit their family members. At the time of the inspection, the relatives designated as essential care givers had temporarily decided not to visit due to the outbreak of coronavirus. People therefore kept in touch in other ways such as the use of computer technology.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● The provider had an electronic safeguarding policy and a procedure which were available to all staff on a computer. Whilst staff spoken with confirmed they had completed training; three members of staff were unsure where to find the contact number for the local authority's safeguarding team.
● On looking at records, we noted allegations of abuse had been raised in the home in November 2021. It was clear the provider had carried out an investigation, however, the allegations had not been reported to the local authority in line with vulnerable adult safeguarding procedures. This meant the local authority had no oversight of the investigation.

The provider had failed to operate effective systems and processes to safeguard people living in the home. This is a breach of Regulation 13 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the registered manager advised the safeguarding procedure had been inserted into the staff handover file and displayed on the staff notice board. They had also compiled an information folder for staff.

● Staff had recorded accidents and incidents on appropriate forms and the information had been added to the electronic care planning system. The data was analysed to determine any patterns or trends. As a result, the registered manager identified a need for an additional member of staff in the evening.
● The provider and registered manager had various ways including electronic systems and handover meetings to ensure information and any lessons learned were disseminated to the staff team.

Assessing risk, safety monitoring and management
● Environmental risks to people's health and safety had not always been assessed and monitored. The assessments are important in order to identify and control risks to people's health, safety and wellbeing. Following the inspection, the registered manager advised they were working on the risk assessments.
● Whilst the provider had arrangements for ongoing repairs and maintenance, it was evident on a tour of the premises, there were instances of unfinished work. At the time of the inspection, the visitor pod had been removed to allow for urgent drainage work. We were assured this would be reinstated the week following the inspection and other work on the premises would be completed.
● The safety certificates pertaining to installations and equipment were complete and up to date. However, the fire risk assessment had expired. Following the inspection, the provider told us this was because the assessor had cancelled on two occasions and they were due to carry out the assessment in February 2022.
● The maintenance officer told us there were no routine temperature checks of the hot water outlets. Following the inspection, the provider assured us these checks would be carried out on a regular basis.
● The provider had a business continuity plan; however, this was limited and did not cover all adverse circumstances. Following the inspection, the provider advised the plan will be reviewed and updated. We also saw staff had developed personal emergency evacuation plans for each person, which included

information on the support people would need in the event of a fire.
● Individual risks associated with people's care and treatment had been assessed and reviewed as part of the electronic care planning system.

Staffing and recruitment
● Recruitment processes were not always effective. We looked at two staff files and noted shortfalls in the documentation. The registered manager assured us these issues would be addressed and the application form will be updated.
● We observed there were sufficient staff deployed to meet people's needs. The registered manager monitored the staffing levels and ensured a safe number of staff was maintained.
● We observed caring interactions throughout the inspection. People and the relatives spoken with were complimentary about staff. One person told us, "The staff are very caring and do their job perfectly" and a relative commented, "I'm happy with the service. They take great care of [family member] and they are approachable and kind."

Using medicines safely
● Medicines were stored and managed safely. Staff were suitably trained to administer medicines and checks on their practice had been carried out.
● The staff maintained appropriate records for the receipt, administration and disposal of medicines.
● The protocols to guide staff on the administration of medicines prescribed 'as and when' required were not available at the time of the inspection. This meant the staff did not have access to the guidance. After the inspection, the provider explained the protocols had been moved to the office, so they could be reviewed, however, staff were not aware of this information at the time of our visit.

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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; continuous learning and improving care

- The systems used to assess, monitor and improve the quality of the service were not always effective. We found a number of shortfalls during the inspection, including the failure to implement robust infection prevention and control practices, the failure to report a safeguarding concern to the local authority and gaps in recruitment records.
- Risks to people's health, safety and welfare had not always been assessed. There was a lack of environmental risk assessments and a risk assessment to assess and manage an outbreak of coronavirus was not seen at the time of the inspection.

The provider had failed to operate effective systems to ensure the quality and safety of the service. The provider had also failed to assess and manage all risks to people's health, safety and welfare. These findings constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager explained they were in the process of implementing systems and ways of working across the whole operation of the home. The registered manager was supported by the provider.

The provider sent us details of their discussions and electronic messages following their checks on the records and environment, along with information about ongoing and planned initiatives. They also sent us a copy of Covid-19 risk assessment dated October 2021.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others

- The registered manager promoted a positive open culture. They often worked alongside care staff to fill gaps in the rota, which meant they had a good understanding of people's needs.
- People and relatives spoke positively about the way the home was managed. One relative said, "[Registered manager] is friendly and approachable and the staff are very kind."
- The registered manager and staff worked in partnership with other agencies including commissioning teams and health and social care professionals. This enabled coordinated care and support for people living in the home.

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

● Whilst people were consulted as part of daily conversations, there was limited evidence of formal consultation and engagement in the service. A satisfaction survey had not been carried out in 2021 and we saw evidence of only one residents' meeting dated September 2021. This meant people had limited opportunities to provide feedback on their experience of living in the home. The registered manager explained they intended to reinstate residents' meetings and carry out a satisfaction survey.

● The registered manager and provider understood the duty of candour and their responsibility to be open and honest when something went wrong. People and relatives were confident the registered manager would take appropriate action to respond to any concerns.

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 The provider had failed to assess the risk of infection and put measures in place to prevent and control infection. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Regulation 12 (1) (2) (h))

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to operate effective systems and processes to safeguard people living in the home. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Regulation 13 (2))

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to operate effective systems to ensure the quality and safety of the service. The provider had also failed to assess and manage all risks to people's health, safety and welfare. These findings constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Regulation 17 (1) (2) (a) (b)).