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:
17 May 2022
06 June 2022

Date of publication:
25 August 2022

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
The Old Vicarage Care Home is a residential care home providing personal care to up to 35 people. At the time of the inspection there were 21 people living in the home. The home is over two floors and there is a lift and stairs to the first floor. The kitchen, dining room and laundry were all on the ground floor.

People's experience of using this service and what we found
People were not in receipt of safe care at the time of the inspection. We saw when accidents or incidents occurred proper investigation did not take place, resulting in a lack of action to keep people safe. Good practices for medicines management were not adhered to as people did not receive their medicines as directed and medicines were not stored safely. Testing of key equipment including fire equipment was not completed. The provider had not recruited staff safely. The provider had not ensured enough trained staff were available to meet people's needs and to implement their emergency evacuation plan.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

There had not been a stable management team at the home for some time and management procedures had not been followed. This included a lack of audit and monitoring of the service delivered to people. Staff did not feel supported and did not have the information they needed to deliver safe care. The provider had not operated an effective governance procedure to ensure action required to keep the building safe was taken when it was required and requirements under the provider's registration including submitting notifications were not completed.

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

Rating at last inspection
The last rating for this service was requires improvement (published 12 September 2020). At our last inspection we recommended the provider reviewed the deployment of staff to ensure people's needs were met. At this inspection we found this had not been effectively acted upon and the provider was found to be in breach of the associated regulation.

Why we inspected
The inspection was prompted in part due to concerns received about the safety of care and support people received. As a result, we carried out a focused inspection to review the key questions of safe and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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 requires improvement to inadequate based on the findings of this inspection.

We found the provider was in breach of regulations associated with safe care provided by enough staff who had been safely recruited and managed well by a competent management team. The provider had also not ensured notifications were sent to CQC as required. The provider took some immediate action to reduce associated risks, but we were concerned this had not led to timely improvements.

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 Care Home on our website at www.cqc.org.uk.

Enforcement and Recommendations
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 monitor the service and will take further action if needed. We have identified breaches in relation to medicines management, infection control, suitable numbers of qualified and competent staff and a lack of effective oversight and quality audit systems, at this inspection.

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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures

The overall rating for this service is 'Inadequate' and the service has been placed in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

The Old Vicarage Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. 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 Health and Social Care Act 2008.

Inspection team
The inspection was completed by two inspectors. Two inspectors were on site for one day and one inspector completed the remaining inspection activity remotely.

Service and service type
The Old Vicarage Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. The Old Vicarage Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was not a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The inspection was in part prompted by information of concern shared with us by partner agencies. We reviewed information we held on our systems and sought additional information from all stakeholders including the local authority commissioning and safeguarding teams. We reviewed the information provided in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with eight staff including the area manager, activity coordinator, senior carers, the chef and domestic staff and received three returns to the staff questionnaire sent to all staff. We spoke with five people who lived in the home and observed all people during the day. We reviewed nine care records remotely and six medicine records were reviewed both on site and remotely. We looked around the whole building including office space, living areas and bedrooms. We also reviewed management information provided by the area manager and generated reports from the electronic care planning system.

After the inspection
We received additional information we requested and reviewed this as part of the evidence for the inspection. We also assured ourselves immediate action was taken to reduce risks and address concerns noted within the inspection.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment
At the last inspection we recommended that staff were better deployed in line with good practice. We found improvement in this area, had not been made at this inspection and concerns had increased.

- There were not enough staff to meet the needs of people living in the home. The area manager had completed a dependency tool which showed enough suitably qualified staff on duty. However, people went without key support needs being met, as care plans used to determine dependency were not an accurate reflection of current needs.
- People started to wake from 5am. At the time of the inspection, care planning information and staff told us of seven people that could need the support of two staff. There were five people in the home that may be able to get up and dressed independently, leaving nine people who required the support of one staff member. We arrived on site at 6.20am to observe the morning routine and found five people already in the lounge. There was no staff supervision in the lounge and people did not have access to food or drink until the chef and day staff came in at 8am.
- At the time of the inspection there were two staff on through the night from 8pm to 8am. There was frequently not a staff member on shift trained to administer medicines to people who may need them. This included 'as required' medicines when people were in pain.
- At the start of the inspection the provider did not have a comprehensive evacuation plan. One was developed on 17 May 2022 by the area manager. The evacuation plan could not be implemented by two staff.
- We spoke with one person who had not been able to get staff attention all night. They had been left without a call bell and staff had not responded to his calls for help. They told us, "I've fallen out of bed a few times and have to shout for help." This had been reported to the Local Authority safeguarding team and the provider ensured a call bell was in the person's room by the end of the site visit.

There were not enough suitably trained and competent staff to meet the needs of people living in the home. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We sought assurances from the area manager that staff concerns would be addressed. Additional management staff were made available during the day, allowing care staff to support people in the home. The dependency tool will be reviewed when care plans accurately reflect people's needs and since the inspection the provider has three staff on each night.

- We were not assured that staff had been safely recruited. We reviewed the recruitment files for four members of staff. There were no files completed , which held the information required under the Schedule 3

guidance of the Health and Social Care Act.
● When recruiting staff, all should be checked by the Disclosure and Barring Service (DBS), these checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. None of the four files held information to assure us these important checks had been done.
● References should be sought from previous employers and if an applicant has worked in social care before then it is advised that a reference is sought from that employer. This will help ascertain the quality of care provided by the applicant in a previous role. We found references were often character references and where references had been supplied by employers they had not been verified.

We were not assured safe recruitment practices had been followed. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Following the site visit we were provided with information on two of the DBS checks and the remaining checks were completed with immediate effect.

Systems and processes to safeguard people from the risk of abuse
● Staff did not follow processes to keep people safe.
● Staff were not trained to keep people safe. When speaking with staff and reviewing records it became apparent that knowledge of when to report concerns was limited. When we looked at training records, we saw only 50% of staff had received safeguarding training in the last 12 months.
●Records showed incidents and accidents that should have been reported and investigated under safeguarding procedures had not been. These included unexplained bruising, people accessing the community independently without the required support and one direct accusation of physical abuse. One person told us, "The male staff member could not get me out of bed, so they just pulled me up." This had resulted in a bruise to person's arm and should have been reported to the safeguarding team. We subsequently ensured that the correct process was followed in light of this provider error

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was not working within the principles of the MCA and if needed, appropriate legal authorisations were not in place to deprive a person of their liberty. There were four people in rooms behind a locked door without an appropriate risk assessment or consent. People had not had their capacity assessed to determine if they understood the restriction and either accepted and agreed to it or it was determined the restriction was in the person's best interest.

Effective procedures were not in place to protect people from abuse. Referrals were not made as required to keep people safe. This was a breach of regulation 13 (Safeguarding service users from abuse or improper treatment) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Since the inspection, the provider informed us all staff have completed safeguarding training.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● Risks to the environment and to people living in the home had not been appropriately assessed to allow suitable risk management and reduction plans to be developed.
● There were no records available to show the fire equipment in the home had been tested weekly as required, to ensure its effectiveness, if needed in the event of an emergency. A referral was made to the Lancashire fire and rescue service to ensure the premises were safe.
● There was no evidence available to show the professional testing of equipment and electric and gas safety installation had been completed within the required time frames. Certificates were provided following the inspection.
● We saw risks to people's health and welfare increasing but risk assessments were not updated to reflect the action staff should take to better support them. This included increased risks of malnutrition due to reduced eating and increased risk of injury due to increased falls.
● We saw assessments which determined one person should repositioned one to two-hourly. When we looked at their records, it was not recorded this had happened, putting that person at increased risk of pressure damage. We also saw where specialist services had recommended specific dietary requirements were followed for people, to reduce the risk of choking, the records did not reflect the dietary needs were implemented. This put people at increased risk of choking.
● We are working with the Local Authority safeguarding and quality teams to ensure people at the home are kept safe and their support needs are met.

An effective system to assess, record and manage risks was not in place. This was breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Using medicines safely
● Medicines were not managed safely. We observed one medication round at the home. When we reviewed medicine administration records (MAR), prescriptions and medicine management we found concerns.
● Medicine bottles, creams and liquids should be dated at time of opening to ensure they are not used beyond their best before date. One eye cream which had been dated when opened, was still being administered a week beyond its best before date.
● People did not always receive medicines to manage pain when they needed them. On over 70% of entries on the MARs for two people that required one or more of these medicines, we saw it could not be administered because it was too soon to the last dose. We found medicines could not be administered at night, due to a lack of qualified staff.
● We looked at the cream administration records and saw that of the eight records we looked at no one was recorded as having their cream applied in line with their prescription.
● The staff member administering medicines told us they didn't feel the training for medicines was sufficient and "That's why some staff wont administer them." The staff member told us, "I did an on-line course, was watched for about an hour and then told I could administer. I only do it as I had proper training before working here."

Procedures were not in place to ensure people received their medicines safely, as prescribed. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● There had not been a management team in place at the home for three months prior to the inspection. As a consequence, systems and procedures for the safe management of the COVID-19 pandemic had not been continued.
● We were not assured that the provider was preventing visitors from catching and spreading infections.
● We were not assured that the provider was meeting shielding and social distancing rules.
● We were not assured that the provider was admitting people safely to the service.
● We were not assured that the provider was using PPE effectively and safely.
● We were not assured that the provider was accessing testing for people using the service and staff.
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were not assured that the provider's infection prevention and control policy was up to date.
We have signposted the provider to resources to develop their approach.

Procedures designed to keep people safe from infection and cross contamination were not followed or implemented. This put people at risk and is a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Visiting in care homes
● At the time of the inspection visitors were entering the home to visit people without any checks on their safety. However, visitors we saw followed correct PPE procedures and were wearing masks and visiting people in their rooms where possible.
● We shared our concerns with the area manager who told us they would ensure procedures would be implemented for better infection control.

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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed 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

- The service was not managed effectively. The provider had not met and sustained compliance with the requirements of the regulations since registration.
- We had not received a notification from the provider alerting us to the registered manager leaving the home and the deputy stepping into the manager role. We were also not informed when the deputy left, and the home was left without a stable management team.
- Since the deputy manager left, audits had not been completed and oversight of the quality of the service provided was not in place. This lack of oversight led to areas of concern not being identified and people being put at risk.
- Monitoring of key risk areas such as accidents and incidents, pressure areas and weight loss had not been completed. This left people at risk of not receiving the support they required.
- There was not an effective operational governance process at the time of the inspection.

Systems were not in place to measure the quality of the service provided and assurances could not be acquired that the service was meeting people's needs. This was a breach of regulation 17 (Good governance) of the Health and social Care Act (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics.

- Staff were not being supported to achieve and deliver good quality care. Staff had not been appropriately inducted to the role they were undertaking, had not received appropriate training, access to team meetings and were not in receipt of supervision. One staff member told us, "The care plans do not match people's routines, one service user gets up all though the night and it's not recorded."
- We spoke with four staff on the day of the site visit who were responsible for supporting people living in the home. Each told us they did not feel supported and did not have the tools they needed to complete the job effectively. This included a lack of suitably trained staff, a lack of suitable equipment including Personal Protective Equipment and a lack of leadership and direction.
- A lack of monitoring of records used to identify people's needs meant records were not accurately reflecting people's needs. Systems were not in place to identify and assess risks to allow effective mitigation of those risks. Handovers did not take place and there was not a record of what needed to be completed on each shift.

● The views of people supported were not sought to ensure their needs were met. People told us they were not involved in how their care and support was delivered.

Systems were not in place to ensure records accurately reflected people's needs, the lack of effective quality assurance meant it was not known if the service delivered met people's needs and reduced associated risks.. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act (Regulated Activities) regulations 2014.

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; Working in partnership with others

● The provider has responsibilities under their registration with CQC to submit notifications of certain events and circumstances. This includes when a registered manager is absent, a serious injury occurs, and someone is suspected of being abused or neglected.

● The provider had failed to send notifications of incidents for some time. This will be looked at separately to this inspection

● The provider had not notified the Commission of changes to the management at the home, this will be looked at separately to this inspection

● The provider must display the ratings from their last inspection. This is to allow people to see how the quality at the home is rated. We found various ways to search the provider's website and not all displayed the rating. We have requested the provider reviews this to ensure the current rating was displayed at each search.

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 19 HSCA RA Regulations 2014 Fit and proper persons employed Regulation 19 (1) a, b, c, (2) a, (3) a A robust and effective recruitment procedure was not in place. systems were not embedded to ensure staff employed were of good character and had the required skills to complete the role applied for. Recruitment information was not gathered in line with schedule 3 of the HSCA.