Creative Care (East Midlands) Limited

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?	**Requires Improvement**

Summary of findings

Overall summary

About the service
The Old Vicarage is a residential care home which provides accommodation and personal care for young adults whom are living with a learning disability and/or autism. At the time of our inspection 13 people were living there. The service can support up to 14 people. The service is split into two units known as 'The Old Vicarage' and 'The New Vicarage'.

The Old Vicarage consists of four bedrooms in the main house and three apartments on the first floor. The New Vicarage consists of five apartments and a two-bedroom cottage. Each apartment is self-contained with bedrooms, bathroom facilities and living space. Each area has their own entrances with dedicated staff teams, communal space, garden space and separate offices for managers.

People's experience of using this service and what we found
People were not always kept safe from the risk of abuse. There were times when people had been left without the support they needed, placing them at risk of harm. Most relatives felt their family members received safe care and support generally. However, some relatives expressed concerns about the frequent changes of management which led to inconsistencies in how risks to people were managed. There were enough staff, but at times, they had not always been deployed effectively. The provider had taken action to ensure people were not left without the support they needed.

People did not consistently receive their prescribed medicines safely. Accidents and incidents were not consistently monitored to identify trends and to prevent reoccurrences. This meant that the opportunity to learn lessons and reduce the risk of future incidents did not always happen.

The service was not consistently well-led. Frequent changes in managers since the last inspection in 2019 had resulted in a lack of robust oversight of the quality of care. The provider worked with the local authority to investigate any incidents or accidents. However, lessons learnt from investigations were not consistently acted on to improve care for people.

Staff understood how to recognise and report concerns or abuse. Risks associated with the service environment were assessed and mitigated. There were clear plans in place to guide staff in what to do in an emergency, and staff knew what the plans were. Relatives and staff felt there were enough staff available to meet people's needs and provide 1-1 support when this was needed.

The service was clean and staff knew how to reduce the risk of acquired infections. We saw some staff did not always wear their personal protective equipment (PPE) correctly. The provider addressed this on the day of our inspection.

The provider had recently appointed two new managers at the service, and relatives and staff told us about the positive impact this had.

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 guidance CQC follows to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

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 due to the number of avoidable incidents that happened at the service, leading to people being put at risk. The provider was working to address the concerns we found to ensure people felt safe and care was person-centred.

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 on 14 May 2019).

Why we inspected
We received concerns in relation to unsafe staffing levels and medicines management. 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 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 coronavirus 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. The provider has already started work on improving the quality of care in response to the concerns we found. 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.

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 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 safe 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.

This was a focused inspection to review the Key Questions of Safe and Well-led only. Our report is only based on the findings in those areas at this inspection. The ratings from the previous comprehensive inspection for the Effective, Caring and Responsive key questions were not looked at on this occasion. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

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
This inspection was carried out by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. They supported the inspection by seeking feedback from relatives over the telephone.

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 care provided, and both were looked at during this inspection.

The service did not have 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. The service had two managers, who were both in the process of registering with CQC at the time of inspection.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority about the service. 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. We used all of this information to plan our inspection.

During the inspection
During the inspection we spoke with three people who used the service and six relatives. We spoke with six staff. We spoke with one of the managers, the director of operations, area operations manager and quality and operations manager. We looked at a range of records including five people's care records and how medicines were managed for people. We also looked at staff training, and the provider's quality auditing system. During the inspection visit we asked provider to give us additional evidence about how the service was managed, which they did. We used 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.

After the inspection
We spoke with staff and relatives after the inspection visit to get feedback from them about the quality of the service. We continued to seek clarification from the provider to validate evidence found and reviewed the evidence they sent us.

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.

Systems and processes to safeguard people from the risk of abuse

- People were not always kept safe from the risk of abuse. Prior to our inspection, CQC received a number of statutory notifications from the provider. These are incidents the provider must let us know about. The local authority investigated these incidents, as this is their responsibility. There were times when people had been left without the support they needed, placing them at risk of harm.
- For example, one person had 1-1 support from a staff member. The staff member left the person briefly, during which time the person was harmed. This incident was avoidable.
- On another occasion, staff had not ensured a car door locking mechanism was in place. A person was able to leave the car, placing both themselves and staff at risk of harm. The same person was also able to partially get past a security screen in the same vehicle to access the driver, putting both themselves and others at risk. A relative and a staff member confirmed they had raised concerns about the effectiveness of the screen before, but no action was taken to review its suitability. This incident was also avoidable.
- We discussed these incidents with the service managers and the provider's quality manager. They agreed the incidents were avoidable. The provider had reviewed risks associated with people's needs and had taken action to reduce the likelihood of incidents reoccurring.
- Staff understood how to recognise and report concerns or abuse. Staff received training in safeguarding and felt confident to raise concerns.

Assessing risk, safety monitoring and management

- Most relatives felt their family members received safe care and support generally. However, some relatives expressed concerns about the frequent changes of management which they felt led to inconsistencies in how risks to people were managed.
- One relative said with frequent changes to staffing, they felt staff did not always know their family member's care plan as well as they should. They described an event where they knew there was specific information in the care plan to support the person well. Staff did not follow the plan, and this led to the person being stressed and anxious.
- Staff felt they had enough time to read risk assessments and associated care plans. Two staff spoke positively about the support they received on their induction from colleagues and management in relation to understanding risks associated with people's health conditions.
- Risks associated with the service environment were assessed and mitigated. The provider had a system in place for regular checks on all aspects of the environment.
- There were clear plans in place to guide staff in what to do in an emergency, and staff knew what the plans were. For example, if there was a fire or power cut. Each person had their own personal emergency

evacuation plan (PEEP) with up to date information about people's mobility and support needs. This meant staff and emergency services would quickly know how to support people safely.

Staffing and recruitment

● Prior to our inspection, information from the provider helped us identify there were occasions when people had been left without the 1-1 support they were assessed as needing. This had resulted in a number of avoidable incidents. We reviewed this with the provider and identified that there were enough staff, but they were not always deployed effectively.

● The provider had reviewed the incidents and staffing deployment, and taken action to ensure people were not left without the support they needed.

● Relatives and staff felt there were enough staff available to meet people's needs and provide 1-1 support when this was needed.

● On the day of our inspection there were enough staff to support people at the service. We also reviewed a sample of the provider's rotas, and established there were enough staff on each shift to meet people's needs.

● Staff told us the provider undertook pre-employment checks to help ensure prospective staff were suitable to care for people. Additional evidence for the provider confirmed this. The provider ensured staff were of good character and were fit to carry out their work.

Using medicines safely

● People did not consistently receive their prescribed medicines safely. The provider identified a number of medicine errors prior to the inspection taking place and told us about this. We looked at how staff who made medicine errors received additional training and support to improve. However, this retraining had not always resulted in a reduction in medicine errors. This meant the provider could not be assured that people always received the right medicine and the right time.

● We discussed this with the managers, who confirmed that new training around medicines and staff's duty of care was being introduced. The provider planned to assess the impact of this training to ensure medicines were managed safely.

● Staff told us they received training about managing medicines safely and had their competency assessed. Staff had also taken action to improve the way they managed people's medicines. For example, reducing the number of staff involved in medicines management to ensure a consistent approach.

● Each person's medicines record had key information about allergies and how people liked to be given their medicines.

● People received their "as and when" (PRN) medication when they needed it. There was guidance in place for people's PRN medicine which told staff when this medication was needed.

Preventing and controlling infection

● We were somewhat assured that the provider was using PPE effectively and safely. Some staff did not always wear PPE in accordance with best practice guidance.

● We were assured that the provider was preventing visitors from catching and spreading infections. We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises. We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed. We were 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 in relation to staff wearing PPE

correctly.

Learning lessons when things go wrong

● Accidents and incidents were not consistently monitored to identify trends and to prevent reoccurrences. The provider acknowledged that this was, in part, due to the frequent changes in management at the service. This meant that the opportunity to learn lessons and reduce the risk of future incidents did not always happen.

● Individual incidents and accidents were reviewed and action taken to address immediate concerns. For example, to obtain specialist support for people, or to review people's needs.

● The managers and provider confirmed there had been a lot of work recently to improve how accidents and incidents were documented, followed up and analysed to make people's care safer. The provider had improved their processes for analysing incidents to determine how to improve the quality of care.

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

- The service was not consistently well-led. Frequent changes in managers since the last inspection in 2019 had resulted in a lack of robust oversight of the quality of care. The provider's oversight of the service during this time had not identified themes of concern and had failed to take appropriate action to maintain safe care in a consistent way.
- For example, there had been a range of repeated medicines errors. Although the provider's audits identified this, there was a delay in putting in additional checks. Competency checks on staff were sometimes carried out by senior staff who did not have good medicines management skills. This meant there had been a risk that further medicine errors would happen. The provider and managers have now improved their medicine management systems and training to reduce the risk of errors.
- There were also a number of incidents where people were left without their 1-1 support. This had led to avoidable incidents. Although the provider was aware of this, no clear action was taken to learn from these incidents and reduce the risk of them reoccurring.
- The lack of consistent management of the service had contributed to staff feeling unsupported in their work. Although staff felt listened to when they shared concerns or ideas for improvement, they did not always see changes to improve the quality of care as a result.
- The provider had recently appointed two new managers at the service. Registered managers 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, both managers had applied to register with CQC.

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

- Relatives felt communication from staff and the managers was generally good. Some relatives expressed concerns about the frequent changes in management in the recent past, and the impact this had on communication. Relatives also acknowledged that the current coronavirus pandemic had restricted their usual contact with family members and staff.
- One relative said, "I feel the staff sometimes listen to me, I sometimes expect a call back but it doesn't happen. And I don't always feel information is passed on." Another relative said, "There has been a lack of consistency from managers for the past two years. There is a new manager now - it is just like we are starting again and hope that we can move on."

● We spoke with the managers and senior management staff about this. They acknowledged that the frequent changes in manager had not been helpful, and that they now needed to prove to relatives that communication would get better.
● Since the current managers came into post, staff told us they felt supported at work and were clear about their roles. They felt able to share ideas for improving people's lives and said they could see positive action taken as a result.
● Staff had good knowledge of people's likes, dislikes, preferred routines and communication needs. One staff member described how this enabled staff to support people in ways they preferred to reduce people's anxiety and stress.

Continuous learning and improving care; 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 worked with the local authority to investigate any incidents or accidents. However, lessons learnt from investigations were not consistently acted on to improve care for people. For example, in ensuring people's 1-1 support staff did not leave them unsupported.
● The provider and manager had systems in place to ensure compliance with duty of candour. The duty of candour is a set of specific legal requirements providers of services must follow when things go wrong with care and treatment.
● One person told us about times when their care had not been good, and how staff worked with them to improve things. The person said they were currently happy with the way a particular issue had been resolved for them, and they now felt safe and happy living at the service.

Working in partnership with others
● The managers and staff team worked with external health and social care professionals to improve people's care and quality of life. Since the start of the coronavirus pandemic in March 2020, visiting health and social care professionals had reduced their face to face contact with people in the service. However, the staff continued to keep in contact with them using a range of technology. This meant people continued to get support from their local healthcare services.
● We spoke with local authority staff involved in investigating safeguarding concerns and overseeing the quality of care. We identified with them that there clearly had been issues relating to the management oversight at the service. However, local authority staff also acknowledged that the provider, managers and staff team were working to improve the quality of care across the service.