Care People Private Limited

The Old Vicarage

Inspection report

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18 December 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This unannounced inspection took place on 12 and 18 December 2017. The Old Vicarage is a 'care home'. People in care homes receive accommodation and nursing or personal care as single packages under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The Old Vicarage accommodates up to 28 people over two floors. During our inspection 17 people were using the service.

There was no registered manager in post at the time of our inspection; the previous registered manager had left the service in September 2017. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. An interim manager had been in post since September 2017 but had not yet applied to the CQC to become registered manager for the service.

People were not always protected from risks associated with the premises and a number of serious safety risks relating to the environment had not been addressed by the provider. People were not always protected from risks associated with their care and support. People were not always supported by sufficient amounts of staff who knew their needs and staff were not always recruited safely. People could not be assured that the management of medicines was safe. The environment people lived in and equipment used was not always clean.

People's rights under the Mental Capacity Act (2005) (MCA) were not always protected as people's mental capacity had not always been assessed robustly and the MCA had not always been applied to ensure that decisions were made in people's best interests. People could not be assured that staff had the skills and training they needed to meet people's needs correctly. People did not always get the support they required to eat their meals in a safe way. People had access to health professionals; however, staff did not always work with them to improve people's health. Information in care plans about the support people required to maintain good health was not always clear. People's individual needs in relation to the premises they lived in, were not adequately met.

Staff supporting people did not always know their needs and people were not involved with the development of their care plans. People's privacy and dignity needs were not always met.

People did not always receive personalised care and their care plans lacked up to date key information to assist staff to provide individualised care. There was a lack of personalised end of life planning in place for people. Social activities available for people were limited and were not tailored to people's individual needs people who spent time in their rooms were at risk of becoming isolated. People's concerns and complaints were not always recorded and responded to appropriately.

The service was not well led. Systems in place to monitor and improve the quality and safety of the service

were not effective and this placed people at risk of harm. Service provision was not robustly monitored and effective action was not always taken in response to serious issues identified. There was a lack of over sight of the service from the provider which had resulted in poor care for people who lived at the service

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

After the inspection visit, further information of concern was received in relation to fire safety. Following this, all people at the service were moved into alternative accommodation. We then issued a notice which proposed to cancel the provider's registration and at the time of writing this report intend to do this.

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

People were not always protected against risks to their personal safety.

The environment people lived in was not always safe and the provider had failed to mitigate risks to people's safety.

People were not always supported by adequate numbers of staff who knew their needs.

People did not always receive their medicines safely.

The environment was not always clean.

Is the service effective?

Inadequate

The service was not effective

People's rights under the MCA were not always protected as the Act had not always been applied to ensure that decisions were made in people's best interests.

People could not be assured that staff had the skills and training they needed to meet people's needs in an appropriate way.

People did not always get the support they required to eat their meal in a safe way and there was a lack of monitoring of people's weights.

People had access to health professionals; however, staff did not work with them to improve people's health. Information in care plans about the support people required to maintain good health was not always clear.

People's individual needs in relation to the premises they lived in were not being adequately met.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us that most of the staff at The Old Vicarage were caring. However, staff we spoke with were not always knowledgeable in relation to people's care needs

People's privacy and dignity were not always respected.

People did not have access to advocacy services.

Is the service responsive?

Requires Improvement

The service was not always responsive

People were at risk of receiving inconsistent support which was not always personalised to their needs.

People's care plans contained limited information about how staff should support them in line with their preferences at the end of their life.

People were supported to take part in some activities, although at other times people were provided with little stimulation.

People could not be assured that concerns and complaints were captured and responded to appropriately.

Is the service well-led?

Inadequate

The service was not well led

Systems in place to monitor and improve the quality and safety of the service were not effective and this placed people at risk of serious harm.

The service provision was not robustly monitored and effective action was not taken in response to issues.

There was a lack of oversight from the provider which resulted in poor care for people.

The Old Vicarage

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 12 and 18 December 2017 and was unannounced. The inspection team consisted of two inspectors and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. We were accompanied on the 18 December by a member of the quality monitoring team from the local authority.

The inspection was prompted by information of concern we received from both the local authority and a whistle blower. We used information we had received from and about the service to plan the inspection. This included previous inspection reports and statutory notifications. A notification is information about important events which the provider is required to send us by law. We also sought feedback from the local authority, who commission services from the provider.

During the inspection, we spoke with10 people who lived at the service and four relatives or friends who were visiting. We spoke with the nominated individual (this is a person nominated to represent the provider), one company director, the manager, one senior care worker, one care worker and one agency care worker, a housekeeper and a maintenance person. We also spoke with a healthcare professional who routinely visited the service.

Inadequate

Is the service safe?

Our findings

The risks to people's safety had not always been appropriately assessed and as a result the risks were not always reduced to keep people safe. The Nottinghamshire fire service had undertaken an audit of the premises in April 2017. Issues of concern were found relating to internal doors at the service not closing properly and the fire strips on the doors had been painted over. This meant should there be a fire at the service, people would not be protected as the doors would not close properly and expand to form a seal and reduce the spread of a fire. Following the audit we had received confirmation from the provider that they had addressed this issue.

However, during our inspection on the 18 December 2017 the Nottinghamshire fire service undertook another audit of the building and found the provider had not addressed the issue of concern identified during their audit in April 2017. The fire service also found further significant concerns about the safety of people on the first floor. The fire officer talked to both permanent and agency staff and they could not be assured that staff had sufficient knowledge of how to manage the safety of people should there be a fire at the premises. The manager or staff on duty did not have access to a number of rooms at the service which were locked so the rooms could not be assessed to check they contained functioning fire alarms. There was also a bare light bulb positioned directly against a wall in one room and a fire extinguisher missing from the first floor. The external fire escape had been blocked by a pile of leaves which would impede any evacuation of people who needed to use this route. The training records showed there was a lack of up to date fire training for staff employed at the service and this included training on the use of fire evacuation equipment in use at the service. The manager and provider assured us the staff would undergo training on the 19 December 2017 and the doors would be addressed on the same day. However due to these and other concerns raised the local authority took the decision to urgently remove people who lived on the upper floor of the service from the home on the 18 December 2017.

The fire service returned to the service on the 20 December 2017 to check if the provider had carried out the work discussed on the 18 December 2017 The fire officer found the work to ensure the doors would close properly had not been addressed and also found further doors on the ground floor, were held open with devices not approved by the fire service. The fire officer also undertook a fire alarm drill to test the responses of the staff on duty and found despite recent training, the staff did not respond in an organised and safe manner. This meant should the alarm have been activated as a result of an actual fire, their lack of response would have put people who lived at the service and visitors at serious risk of harm. As a result of this the local authority took the decision to remove the remaining people from the service on the 21 December 2017.

The service's lift had had an intermittent fault since the 10 November 2017 when during a night shift, one person was stuck in the lift which had stopped and did not meet the floor level. Staff on duty did not know how to re - set the lift externally and called the fire brigade to support them to evacuate the person from the lift. Following this incident the maintenance person was required to re - set the lift externally as it continued to breakdown when staff attempted to use it. On the 13 November 2017 the lift broke down again and could not be manually overridden and the manager needed to call out the lift engineers to repair the lift. The lift was out of service for half a day. Whilst the lift company was able to temporarily repair the lift it still

continually failed after use and needed externally resetting after each use. Staff also reported weight in the lift was an issue and any more than one person at a time caused the lift to breakdown after each use.

The service had failed to notify us of the continuing problems with the lift until the 22 November 2017 when we had received some information from an external source that there were problems with the lift and we contacted the service to establish what the problems were. The local authority Quality Monitoring team, who visited the service on the 4 December 2017, also raised concerns over the continued problems with the continuing functionality of the lift and the lack of response to the issue by the provider.

There was no risk assessment or action plan in place to identify the risks to people who could not be transported downstairs without the use of the lift, or how their care would be managed whilst there were ongoing problems with the lift. This had resulted in staff and people not having a clear understanding of whether the lift should or should not be used. At our inspection on the 18 December 2017, we were told by a member of staff, before we had arrived, one person who lived at the service had used the lift independently. Staff had been unaware the person had used the lift and there had been no signage or information to make the person aware they should not use the lift. This lack of clear planning and robust assessment had placed the person at risk of harm.

During our inspection we were made aware of a continuing problem with the service's call bell system. There were times when the source of the call would not sound or be displayed to alert staff that people needed assistance. On their visit on the 4 December 2017 the local authority raised concerns with the provider about the call bell issue who assured them they would discuss the issue with their engineer and rectify this. It was clear on the 18 December 2017 during our inspection and conversations with the provider that whilst they had discussed the call bell issue with their engineer, they had not put in place the measures suggested by the engineer to manage this. The information had not been shared with the manager or staff at the service to enable them to monitor the effectiveness of the measures suggested, or check if these measures rectified the issue and effectively supported people when they required assistance from staff.

Staff we spoke with told us that equipment in use meant to reduce the risk of harm to people was not always fit for purpose. For example, one person had recently fallen out of bed and they had agreed to have bed rails in place. A member of staff told us that the person's bed rail was not functioning properly and dropped suddenly to the floor if operated, this could potentially cause injury to the operator. There was not a spare bed rail of the appropriate type at the service and the piece of equipment continued to be used despite the issue being reported by staff to the manager and maintenance person five days previously. This information of the fault had also not been widely shared with staff. A further staff member we spoke with told us they had not been informed of the problem and had operated the bedrail which had dropped to the floor. There was no assessment of the risk of the continued use of the bed rail in place and no evidence that alternatives had been considered, this put the person of further injury and staff at risk of injury.

The above issues show the provider to be in breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff did not always have the knowledge to ensure equipment at the service to reduce the risks to people's safety was used as it was intended. One person, who had reduced mobility and had recently fallen out of bed sustaining a head injury, was also at risk of skin damage. We checked the person's bedroom and found they had a divan bed with an over lay cushioned pressure relieving mattress on top of a standard mattress. This meant the bed height was approximately a metre from the ground, and staff could not adjust the height of the bed to assist the person into bed and then lower to reduce the risk of injury should the person fall out of bed. When a person is at risk of skin pressure damage care homes are able to obtain equipment such as

adjustable height beds. We saw no evidence that this had been requested by staff. They had placed a full thickness pressure relieving mattress on the floor beside the bed to reduce the risk of injury. However, this was poor use of equipment as if the person had been using the correct bed; a crash mat could have been used to reduce this risk. We identified another person who was known to be at risk of skin damage who did not have a pressure relieving mattress on their bed. Had staff used the equipment available to them in the way it was intended they could have reduced risk of harm to other people at the service.

People did not always receive their medicines as prescribed. During our inspection we found a number of serious concerns in respect of medicines management. We found hand written prescriptions on some people's Medicine Administration Record (MAR) that did not contain two signatures to show they had been checked by staff. Some MAR's lacked essential information for staff to safely administer medicines. For example, following a recent discharge from hospital one person had a hand written medicine on their MAR which showed no dose or frequency of how the medicine should be given and staff had not been administering the medicine. This was because they had been unable to obtain the medicine and prescription from the GP as the person's hospital discharge summary had been sent to the wrong GP surgery by the hospital. Whilst we saw an entry on the MAR by a member of staff to ring the surgery to expedite the receipt of the medicine, there was no evidence to show this had been done and the person had been without the medicine for a number of days. Another person had been prescribed a medicine and was meant to be receiving a gradually reducing dose of this medicine. The MAR did not show what dose the person should be receiving as the instruction from the GP could not be found and the staff on duty could not tell us what dose the person had been receiving. This lack of care in relation to the management of medicine meant the people were not receiving safe treatment for ongoing medical conditions. This placed people at risk of harm via the deterioration of their physical health and wellbeing.

There was a lack of environmental cleanliness at the service. During both our visits we found significant concerns in relation to environmental cleanliness. For example, on both occasions we noted the dining chairs had visible dust on the frames of the chairs and there was dust and food debris on the sides of the chairs. We highlighted the issue on our first visit but the issues were not addressed. We also noted one person who had been required to spend time in their room, as a result of the lift failure, lacked a bedside table. We saw the lid of the person's commode was being used to put their tea cup on. This meant the person had been required to use the commode as a bedside table. We examined two toilets and found one did not have a light in the room and both were contaminated with bodily fluids. This failure to ensure the cleanliness of the service did not promote good infection control procedures and therefore placed people at risk of harm.

People were also not protected from risks associated with the environment. During our inspection on both days we found cleaning fluids which should have been locked away when not in use, were left unattended in rooms that could be accessed by people who lived at the service, some of whom were living with dementia

The above issues show the provider to be in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People we spoke with felt the staffing levels and the staff knowledge of their needs were insufficient. One person said "No, they've not got enough on. It's worse when you want to go to the toilet and have to wait." The person told us sometimes they had not been able to get to the toilet in time. Another person told us there appeared to have been some recent increase in staff levels, although a large number of the new staff were agency staff. The person said, "They got agency in so they don't know us." A further person said, "They could do with a few more that know us."

Staff we spoke also raised concerns about staffing levels. One member of staff told us the staffing levels had been increased just before our inspection. This had followed an inspection by the local authority who had raised concerns with the provider about staffing levels at the service. One member of staff told us there were still some issues on some shifts and it was made more difficult, as the lift was not working safely and staff needed to check and provide care for people who had to stay upstairs. They told us the previous weekend they were short of staff due to staff sickness and it was not possible to find a replacement. They also told us the provider had reduced staffing levels approximately a month ago, by reducing the hours people worked and this had impacted on the staff's ability to provide safe care for people.

We spoke with a health professional who visited the service regularly, they told us they had concerns in relation to staffing levels and had recently reported their concerns to the local authority. The health professional told us they often could not locate staff when they wanted to speak with them, in addition they had witnessed that some people at the service were not assisted with their daily hygiene until very late in the morning. During our inspection we spoke to a person who was in bed but was requesting assistance with their personal hygiene and to get up. Two hours later we saw the person was only just eating their breakfast at 11.20am.

Our further observations of staff practices showed that at times, people were not receiving adequate personal care. For example, we witnessed one person who had been incontinent of urine whilst trying to get to the toilet. The person was still in their nightwear and a member of staff came to assist the person to the toilet. Approximately 10 minutes later, we saw the person being assisted out of the toilet fully dressed and escorted to the breakfast table in the dining room. The toilet contained only a hand basin which would have been insufficient for the staff member to use, to assist the person with a full wash. This meant the person was not receiving adequate support with their personal care needs.

Throughout our visit on the 12 December 2017 we saw there were long periods when the communal areas of the service were not monitored by staff and throughout our inspection we saw that staff were not always deployed or managed effectively. As well as our own observations a health professional we spoke with told us when they had visited, they had noted there were times when there was a lack of staff working on the floor and staff were taking breaks when people were in need of assistance. We also witnessed one person trying to assist another person by moving a heavy chair the person was sat in. Both people had limited mobility and did not appear to understand the risks associated with this action. We intervened as we saw that both people were at risk of harming themselves. We went to find staff to support these people but it was some minutes before we could locate them as the staff team were delivering meals to the people on the first floor of the service. We raised our concerns regarding the safety of the people in the dining room and the lack of supervision and following this, a staff member remained in the dining area to support people. We also raised this lack of organisation and deployment of staff to the manager who assured us they would address the issue.

The above shows the provider to be in breach of Regulation 18 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2104

Staff recruitment processes were not always safe. Whilst there was evidence of Disclosure and Barring Service (DBS) checks in place for those staff that had started employment at the service (these checks are to assist employers in maker safer recruitment decisions). Some information in staff files in relation to staff references were missing. For example, one person's file contained only one reference, and another had no references. In relation to the latter, the member of staff told us the employer had obtained a verbal reference prior to their employment but the file did not contain evidence of this. This meant the provider's recruitment processes were not always safe, and people were not always protected as the provider lacked

the information to assure themselves that the staff they employed could safely provide care to people at the service.

People we spoke with at the service did not always feel safe. The lift malfunction was the cause of a large number of concerns raised by the people at the service. One person said, "I am not really safe as it's the lift. Now I can't go down and I like to see people around me. I don't like it here (the makeshift dining room on the first floor)." Another person we spoke with told us they felt they were in a 'prison' as they were unable to move safely around the home as they normally did. Some people also expressed their concerns that the agency staff who had been brought in to the service did not know them and they did not have the same confidence in the agency staff as they did the permanent members of staff.

Staff we spoke with were aware the types of abuse people could be exposed to and told us they would report any concerns to the manager. They were confident the manager would take action to investigate their concerns. But staff also told us if they were not listened to they would go to the senior management or the CQC.

We were aware of one serious safeguarding incident that had been investigated by the manager. The manager had been open and transparent with the person concerned and had undertaken an investigation into the incident. They had also put in measures to further support the person and discussed the changes with the staff involved in the incident.

Inadequate

Is the service effective?

Our findings

People we spoke with told us staff gained their consent before providing them with any care and they were able to make choices with their care. One person told us, "I do things when I like, I say when I want to go to sleep or have a wash. The (staff) help me choose what to wear."

However, our conversations with the manager and the care plans we viewed, showed there was a lack of knowledge in relation to the Mental Capacity Act (MCA) 2005 and how it should be applied to support people at the service. The 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 Act 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.

We looked at the records of one person which had recorded the person had a mental health condition and had been deemed to lack mental capacity. There was no evidence to show how this assertion had been reached. There was information in the GP records to show a diagnosis of a medical condition had been made and that a relative had been given consent to view the person's medical records. There was also a document in the person's care plan called "Initial capacity assessment form." The form was a one page document that did not show how the assessment had been made. There was no evidence of the two stage test to show if the person lacked the ability to understand and retain information. There was a list showing the simple decisions the person could make about areas of basic care, food and clothes choices. There was also a list of decisions the person had been deemed not to be able to make, such as the decision to live at the service or awareness of dangers and hazards in the service. But these assertions were not supported with any documentation, to show the decisions had been made in the person's best interests and were the less restriction options for this person or whether alternative options had been considered.

People's rights under the Mental Capacity Act 2005 (MCA) were not respected. People's care plans lacked meaningful mental capacity assessments to assist staff to support them with decisions to provide care in their best interests.

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 MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).We checked whether the service was working within the principles of the MCA and DoLS, and whether any conditions on authorisations to deprive a person of their liberty were being met. The manager told us there were a number of people who they felt were being deprived of their liberty unlawfully, and these people had not been assessed to establish if a DoLS was required.

We reviewed the documentation provided in relation to a person who had previously had a DoLS authorisation in place. The records indicated the authorisation had expired and there was no evidence that this had been renewed. The manager told us another application had been submitted but was unable to

provide evidence of this. This meant the person was being unlawfully deprived of their liberty and the service was not working within the principles of the MCA and DoLS.

A further example the service was not working within the principles of the MCA and DoLS was that one person asked and made attempts to leave the premises, however staff felt the person would not be safe to do so and stopped them. During our inspection we saw the person ask a number of times when they were going home and at one point attempted to open fire doors to leave the building. We viewed the person's care records and saw there was no mental capacity assessment to establish if a DoLS was required for this person.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People's needs were not always assessed using nationally recognised tools. For example, we saw the falls risk assessment tool used had been developed by the manager without an evidence base to support it. We asked the manager how they had developed the tool and they told us they had used the knowledge gained from a service where they had previously worked and had developed the tool with this. However, they could not tell us which validated tool had been used as a base for their assessment tool and whether they had followed the assessment and scoring system correctly. This meant the risks to people's safety may not have been assessed appropriately to protect them from harm.

Whilst we saw the manager had used nationally validated tools to help them assess needs such as pressure area care or nutrition, the tools were not always completed correctly to give staff the information they required to provide the best care for people. For example, one person's care record showed they had an underlying medical condition which affected their nutrition but this was not recorded on their nutritional assessment tool. This also meant the person's nutritional needs had not have been assessed correctly putting them at risk of receiving inappropriate care in relation to their diet.

We received mixed feedback in relation to staff knowledge and skills. One person told us they thought the care staff were, "Brilliant," and did things the way they liked them done. But another person said, "Some (staff) know what they're doing but we get a lot of agency - they're friendly enough though." A number of people expressed concern at the amount of agency staff and one relative we spoke with said, "There used to be a regular team but now the agency (staff) are strangers to the people."

Staff we spoke with told us there was a lack of staff to allow them to have time to complete training to assist them in their role. One member of staff said they had not received an induction as the service was too short of staff and they had to start work immediately. Another member of staff who had started at the service recently, said the manager checked their training certificates to ensure they were up to date with their training but they had not received any training since starting at the service. A health professional we spoke with also told us a training session had been arranged for staff recently by the manager and another health professional but on the day there had been no staff available to attend the session.

The manager told us the staff training was not up to date and despite requesting a training matrix we were not supplied with one. The manager told us there were particular aspects of their role that staff had not received training on, for example the use of the evacuation slide used in the event of a fire to evacuate people from the first floor had not been undertaken. This placed people at risk of serious harm in the event of a fire at the service.

This was a breach of regulation 18 (2) (a) of the Health and Social Care Act 2008 (regulated Activities)

Regulation 2014.

People we spoke with told us generally the food at the service was good. Whilst staff we spoke with showed knowledge of people's diets, we found examples to show people's weight and dietary intake were not monitored to ensure they maintained a healthy diet. For example, we looked at one person's care records and saw when the person had last been weighed at the end of October 2017 they had an unplanned weight loss of 2.4kg over the space of one month. However, despite this weight loss no further monitoring of their weight had been undertaken by staff. The person's care record noted they required a fortified diet and staff were to offer the person regular snacks. The care records also noted the person required a fork mash able diet and thickened fluids. This had followed an assessment by the speech and language therapy (SALT) team as the person had some difficulty swallowing and was at risk of choking. During our inspection we observed the person in the dining room; they gave their breakfast to another person. The staff were not monitoring the person whilst they were eating and came to remove the person's plate. It was necessary for us to highlight to staff that the person had not eaten any breakfast and a few minutes later a member of staff came and offered the person some alternative choices for their breakfast.

However, our observations showed the person ate only a small amount of breakfast and despite their care records informing staff to offer snacks throughout the day the person was not offered any extra snacks as stated in their care plan. There was also lack of thought to the portion sizes the person was offered at mealtimes. The lunchtime meal presented to the person was a large portion and it was clear through our observations, the person struggled to eat it. They ate less than a quarter of their main meal and again tried to offer it to the person they were sitting with. The person records also showed that although they were required to drink thickened fluids they sometimes drank tea from another person's cup. Despite this being recorded there was a lack of monitoring of the person when eating and drinking. This showed a lack of safe and effective management of the person's nutritional needs.

People told us they had access to healthcare professionals and there were regular visits from health care professionals such as community nurses, opticians and chiropodists. However, staff we spoke with and the care records we viewed, showed that staff were not supporting people and health professionals to ensure people received co-ordinated and effective care. Staff were unable to explain the treatment being provided for one person we asked them about. The person's records also lacked consistent information about the care provided and the person's care plan made no reference to the parts of the person's care the community nurses were contributing to, or their progress. There was also a lack of information about what people should do in between visits or when to call the community nurses.

A visiting professional we spoke with said when they visited, staff let them into the home but did not accompany them or offer support. In addition, they said they could not always find a member of staff to feedback information at the end of their visit, and when they did, sometimes the staff did not seem interested. They said there was no system within the service for them to record their input for staff. The health professional had highlighted communication as an issue with the manager and said staff did not always follow through on action they asked them to take. For example, a urine specimen was required for a person who the visiting health professional thought might have an infection. They left the equipment to enable staff to collect it, but when they returned the specimen had not been collected and the equipment was missing. As a result they had to repeat the process again. This lack of organisation and communication between the staff at the service and the visiting health professionals put people at risk of receiving inappropriate and poor care.

People's individual needs at the time of the inspection in relation to the premises they lived in were not being adequately met. The people who lived on the first floor of the service had been unable to regularly

access the main living areas on the ground floor. This had impacted on people who enjoyed socialising with other people. One person we spoke with said, "No lift is a nuisance as I'd rather be downstairs and getting some fresh air too. I've no freedom." During our visit on 12 December 2017 we saw one of the bedrooms had been adapted as a small lounge. However, the only concessions made to the room was for the bed in the room to be pushed back against the wall and staff had put four chairs and a television in the room. At the time of our visit there were nine people who had bedrooms on the first floor. One person said, "The lounge is too small for us." During the morning we also saw that people had been required to have their meals sat against their chest of drawers in their rooms. We raised this issue with the manager and asked that they provide a dining room on the first floor for people to use and that they remove the bed from the temporary lounge. We saw later that staff had removed the bed from the temporary lounge and moved some dining tables and chairs into empty rooms on the first floor for people to have their meals. However, these were the only items of furniture in the room. There was a lack of condiments and storage facilities for cutlery and no other adaptations had been made to the room to improve people's dining experience.

When we revisited the service on the 18 December 2017 we looked in the dining room and found there had been no further improvements. We saw the tables had not been cleaned after a mealtime and there were tissues on the floor. The manager had moved the lounge to a slightly bigger room on the first floor; however people and their relatives were unhappy about the lack of chairs available for visitors to sit on. One relative told us some friends had visited the previous day and had been required to stand throughout their visit, as not only were there no chairs for them to sit on there was no space to put extra chairs in the room. Another person said, "I am not enjoying it up here in the lounge or dining room." We saw the upstairs temporary lounge was small, had a malodour and lacked any chance of privacy for people. There was also no signage for people to show which rooms were being used as a lounge or dining room. During our inspection on 12 December 2017 we found one person who lived at the service and lived with some mild confusion, was wandering up and down the corridor on the first floor unsure of where they should go to sit down. This lack of signage and support had added to the person's confusion and difficulties to orientate around the service.

During our visit on the 18 December 2017 we also found a number of wheel chairs being stored in a person's bedroom. The bedroom was next to the temporary lounge and staff had decided it was more convenient for them to store the wheelchairs in this room rather than putting the wheelchairs in each resident's rooms. However, this had not been discussed with the person who lived in this room and meant they would not be able to spend time in their room during the day should they want to. These temporary adaptations made to the environment by the provider did not meet the needs of people at the service or help them maintain their independence.

Requires Improvement

Is the service caring?

Our findings

We received mixed views from people in relation to the care they received from staff. People felt the staff who worked permanently at the service did know their needs and supported them in the way they wanted to be supported.

However, our conversation with staff did not always support what people had told as there was a lack of knowledge amongst the permanent staff about people's needs. For example, we checked the records for one person which noted the person had had two pressure ulcers. However, it was unclear whether they had healed or not. In addition the person had a healing wound from a recent operation. We asked staff what input the person was currently receiving from the community nurse and if the person's pressure ulcers were healed. They were unsure what treatment the person was receiving.

A number of people felt the lack of permanent staff and introduction of agency staff had impacted on their care. One person said, "It depends on the carers as some are better than others. Strangers don't know us and what we like. There seems to have been a lot of them lately." Our observations of practice supported these views. For example, two people who lived with dementia spent the majority of their time together and did not like being apart for long periods of time. We saw an agency worker escorted one of the two people into the dining room for lunch and then explained to them the other person had chosen to stay in the lounge. The person accepted this and ate their meal. However, following their meal they became mildly distressed and began wandering around, they were unable to verbalise clearly that they wished to be with the other person as their language was confused. Whilst our limited knowledge of the person gave us reason to believe the person wanted to return to the lounge and sit with the other person, they appeared not to know how to get back to the lounge unaided. The agency staff did stop to talk to the person but there was no attempt to direct them back to the lounge and the person they were looking for, until we intervened and suggested this was what the person wanted. The staff member then did take the person back to the lounge where they settled sitting next to the other person.

The feedback from people and their relatives in relation to how they had been supported to be involved in the decisions made about their care was mixed. All the people we spoke with told us they had not had any input with their care plans, some people told us their relatives had some input in to their care plan but was unsure of how much. One person said, "My family visit and do all my paperwork. They chat to the manager." However one family we spoke with told us they felt communication was not always good and they did not feel involved with their relative's care as much as they wished. Another relative told us they had been told by staff they could read their relations care plan but they had not been able to contribute to it. The relative told us their relation had attended a hospital appointment that they had not been told about.

Some people we spoke with also expressed preferences in regard to the gender of care worker they preferred to have support them. It was clear from the conversations that this wish had not always been supported and one person said, "I didn't like it when there were more male carers – there used to be a lot more of them."

The care records we viewed lacked information about any of the issues people and their relatives discussed about their care. For example, to show if people had agreed to input from relatives in relation to their care and treatment, or whether there had been discussions on people's preferences on how they wished to be care for. We could find no evidence to show there had been any involvement of people or their relatives in the development of their plans.

No one who lived at the service was using an advocacy service to support them make independent decisions. An advocate is a trained professional who supports, enables and empowers people to speak up. Whilst the manager was aware that these services could be made available for people there was no information available or on display at the home for people who may need these services.

People's privacy and dignity was not always observed. Whilst some people told us staff knocked on their doors before entering and closed curtains before providing care. Others told us staff did not always knock before entering. One relative we spoke with told us their relation's continence needs were not always supported to help maintain their dignity, as they came in regularly to find their relation sitting in wet clothes. Whilst staff we spoke with were able to tell us how they would preserve people's privacy and maintain their dignity, our observations of practice did not support this. There were examples of people not being supported in a dignified way in relation to their basic personal care needs. There were occasions where people were inappropriately dressed in communal areas for example we saw one person walking with a member of staff in their underwear. We observed one person during a meal time pouring milk onto their bread and butter. Another person who they were sitting with raised this to a staff member who said, "Oh yes don't worry they do that." The member of staff did not intervene and support the person to prepare and eat their meal in a dignified way and showed a lack of empathy towards the person and their needs.

The above issues show a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

People were at risk of receiving inconsistent or unsafe support. Whilst some people's care plans provided staff with some personalised information on their preferences, we found majority of care plans did not contain up to date relevant information in relation to people's needs. There was often key information missing and the information around people's care was not current. This meant staff would not have essential up to date knowledge of the appropriate care people required.

For example, one person had a number of different skin conditions that required different creams. There was no care plan in place to support staff to assist the person to manage their condition and their MAR did not make it clear what cream should be used for which condition. We spoke to the person who could not remember which creams should be used and relied on staff to tell them what should be used and when they should be used. With the increased use of agency staff this meant there was not sufficient information to assist staff to support this person with their condition which placed them at the risk of harm.

A further example of the lack of consistent care for people was the lack of clear documentation for a person who was at risk of developing pressure ulcers. The person told us they required assistance to move their position to reduce the risk of pressure ulcers and they were currently cared for in bed. This information was not in their care plan, and the daily records we viewed included repositioning charts for this person that showed the necessary care was not being given. For example, daily records showed the person was not repositioned on the 11 December 2017 between the hours of 6.30am and 2pm and between 6pm on the 11 December 2017 and 9.30 am on the 12 December 2017. Staff we spoke with could not tell us when the person had last been repositioned or what the repositioning regime was. This placed the person at increased risk of developing pressure ulcers through lack of effective care.

We viewed the care of another person whose mobility care plan showed they were able to rise from a chair and walk with the aid of a frame and the support of one member of staff. However, during the preceding month the person's mobility had been reducing and an entry in the person's daily record stated they had fallen on the 19 November 2017. The entry noted the person required more help to rise from a chair and was unsteady when walking. This information had not been updated in the person's care plan so agency staff would not have been aware of the deterioration in the person's condition. During our inspection we saw the person was transported from one place to another with the aid of a wheel chair. There was no evidence in the person's care plan of any referrals to health professionals to establish any underlying reasons for this deterioration in the person's condition or any support such as physiotherapy to assess the person's condition.

A further person we spoke with had been admitted to the service after a deterioration of their mobility following a fall at home. The person told us they had suffered a further fall at the service following their admission and was meant to have a're-enablement' package of care in place to assist them to return home (re-enablement supports and encourages people to regain independence with daily tasks). This was to include physiotherapy support; however the person and their relative were unhappy as the person had only seen the physiotherapist once since being admitted to the service. We could find no evidence in the person's

care plan of a re-enablement plan in place for the person and there was no evidence that staff were supporting the person to improve their mobility. We spoke with staff to ask if they were supporting the person improve their mobility, and whilst they encouraged the person to be as independent as possible when providing personal care, they had not undertaken any extra exercises with the person and were not aware of any instructions in place to do this.

The above examples show a clear lack of responsive care that impacted on people at the service and is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was some information in people's care plans about their social preferences and people told us that a care worker was identified to support social activities three afternoons a week. Both people and staff we spoke with told us they were sometimes called away to support people's personal care needs. There was no evidence to show people's particular preferences had been catered for and staff were unable to give examples of any particular activities that had been undertaken to meet any individual social needs. One person said, "An outsider comes in to do singing. Some days we have a craft thing to do." A relative we spoke with told us there was bingo for people occasionally and they had brought in some board games for people to use. No one who was cared for in their rooms could recall any one to one time spent with them to meet their social needs.

During our inspection there were no social activities taking place other than some people watching television. People felt the problems with the lift had impacted on their feelings of isolation. One person we spoke with told us they had no one to talk with and they missed the company. The lack of time and staff allocated to support people's social needs had impacted on people and meant a number of people were at risk of increased feelings of isolation.

People and their relatives were not invited to express their views about their care but people and relatives we spoke with told us they would know who to complain to should they have complaint. One person told us they had in the past complained about small issues and sometimes these had been resolved and sometimes they had not. However, the person told us if they were concerned they would go to the manager. A number of people and their relatives had complained to the manager about the lift and told us they had responded to their complaints; however no one we spoke with knew who the provider was and how they would contact them to address any complaints. Staff we spoke with told us they would address complaints from people and relatives, and they had confidence the manager would address any issues they raised to them on behalf of people and relatives at the service. The manager told us they had not had received any formal complaints however we were aware of some complaints raised to them, and how they had been addressed. We were unable to see these as the manager had not kept any records to show how these complaints had been resolved. They had not followed the company's complaints policy so we could not see the measures undertaken or if they had looked at ways to prevent reoccurrence of these issues.

There was a lack of engagement with people in relation to end of life care. Whilst we saw there were some Do Not Attempt Cardio Resuscitation (DNACR) orders in some people's care plans there were no further documents to indicate conversations regarding people's wishes in planning their end of life care. There was no evidence of human rights and diversity training for staff. We spoke to the manager about what work they had undertaken to address this area of people's care and they told us although they had tried to engage with relatives the only information they had been given was in relation to what undertakers had been engaged to manage people's funeral arrangements. This showed a lack of sensitive advanced planning to ensure that people's end of life care would meet their needs and preferences.

Inadequate

Is the service well-led?

Our findings

The service was not well led. Throughout our inspection of The Old Vicarage we identified a number of shortfalls in the way the service was managed, this included concerns related to the safety of the service, relating to the environment and individual's safety, staff recruitment, compliance with the Mental Capacity Act 2005, dignity and respect, and person centred care. This led to multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was no registered manager at the service as the previous registered manager had left the service in August 2017 and was in the process of deregistering with the CQC. The provider had employed a home manager who had been at the service for three months and was yet to register with the CQC.

There was a lack of clear provider leadership at the service and a lack of support for the manager who was new in post. Whilst the provider told us the manager could contact them at any time, there was evidence to show they had not acted promptly on issues raised to them by the manager in relation to the environment. For example, it had taken the provider over a month after it had first been raised to them, to place an order for a part for the lift which had a serious on going fault that had resulted in a person being stuck in the lift on one occasion. There was also evidence to show when the provider had investigated issues raised to them by staff, such as the ongoing problems with the call bell system, but they had not fed the information they had received back to the manager and staff to assist them to monitor and possibly resolve issues of concern.

Our discussions with the manager showed they required support in a number of aspects of their role that had not been addressed by the provider through supervision and training. This had impacted on a number of areas of care at the service, such as the lack of mental capacity assessments for people, which led to the principles of the mental capacity act not been followed and the use of un-validated assessment tools to identify specific risks to people. Which meant risks to people may not have been safely assessed.

There was evidence to show non-compliance with other statutory bodies. Following an inspection of the premises by the Nottinghamshire fire service it was highlighted that some fire doors at the service did not fit correctly into the frame and meant they did not close properly. The provider informed the fire service the work to address this had been undertaken but following a re-visit by the fire officer, it was found the work had not been completed and people living at the service were still at risk.

Whilst we saw the provider had undertaken regular servicing of essential equipment used at the service, they had not used the information provided by the professionals they contracted to safely manage the ongoing use of equipment. During our inspection we viewed records that showed the lift had been serviced regularly by a company commissioned by the provider. The records from the last two visits in January 2017 and May 2017 showed the company had highlighted that the part that was the cause of the continuing fault on the lift required replacing as it was worn. Despite this and their knowledge of the problems, the provider did not order the part for the lift until the 5 December 2017. These issues resulted in people receiving poor care at the service.

The service lacked a clear quality monitoring framework resulting in issues of concern not being addressed and this had an impact on the quality of care people received. There was a lack of environmental audits to monitor the cleanliness of the service and this had resulted in areas of the service and some equipment we viewed, not being cleaned regularly and showing visible signs of dust and debris. Although we saw there were some check lists completed to show items of equipment were stored correctly. We saw that at times actual checks ticked as completed could not have taken place. For example, on our tour around the premises we found personal protective equipment (PPE) stored on the floor of one room and the check list on that day had been completed to state the equipment was stored in appropriate holder off the ground. This meant staff were not using the auditing processes to identify and address issues of concern so they could be rectified.

We discussed the monitoring of falls in the service with the manager. Although the manager recorded the number of falls in the service each month showing where and what equipment was involved, there was no further analysis of trends to identify patterns and look at ways falls could be reduced. The number of times individuals had fallen and what, if any, measures had been put in place to support people to reduce their falls had not been recorded. A thorough analysis of falls looking at the times, areas where falls happen, staff levels and allocations, and measures already in place would give the manager an oversight that would assist them in reducing any trends. The lack of this robust analysis meant that people continued to be at risk of falls that could be prevented.

Whilst we saw there were monthly medicines audits these audits did not identify the significant issues we found when we looked at the management of medicines at the service. The medicines fridge was not locked and there was no key for it, topical creams and ointments had not always been labelled or dated when opened and there were number of individual issues relating to people's medicines such as gaps in the MAR sheets and on checking we found their medicines had not been given. None of these issues had been highlighted or addressed by the monthly audit and meant people continued to be put at risk of unsafe treatment in relation to the administration of their medicines.

The lack of this regular analysis showed that as well as the lack of effective measures in place to manage some of the individual risks to people meant there was a lack of effective governance in relation to managing risk in the service.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

The provider had also not undertaken their statutory duty in informing us of events at the service. For example, the on-going problems at the service with the lift was not reported to us by the provider until we contacted them following information we had received from another source.

This was a breach of Registration Regulations 18 (2) (a) Care Quality Commission (Registration) Regulations 2009.

There was a lack of engagement with people at the service. People at the service told us there were no regular meetings to discuss their views on the quality of the service. One person said, "They just do a verbal chat about how things are for me." A relative we spoke with told us there had been one meeting with the manager when they first arrived at the service and one on the 18 December 2017 to discuss the ongoing problems with the lift.

Staff we spoke with told us there had been a meeting with the manager approximately two months ago and

told us they had been able to voice their opinions and felt the manager had listened to them. The manager also told us they had undertaken regular supervisions with staff and was working to try to ensure staff had an understanding of their roles and responsibilities.

However, during the previous few months there had been a large turnover of staff and some of the staff we spoke with were unhappy with their working conditions and felt they and the manager were not supported by the provider. One member of staff said, "I'm not staying here." They told us they had worked in care for a number of years and said "(I) have never worked in a place like this, It's so frustrating." A further member of staff told us the manager was blocked by the provider when they tried to improve things at the service.

These issues resulted in the service lacking direction and clear leadership; there was no evidence that the provider had monitored the service to assure themselves of the quality of the service provided. This had accumulated in people receiving an inadequate service which impacted on their health and wellbeing.