

Dr Pepper's Care Corporation Limited Vicarage Residential Home Inspection report

1 Honicknowle Lane Pennycross Plymouth PL2 3QR Tel: 01752 779050 Website:

Date of inspection visit: 12 September 2015 Date of publication: 21/10/2015

Ratings

Is the service safe?

Requires improvement



Overall summary

We carried out an unannounced comprehensive inspection of this service on 7 & 8 May 2015.

Following the comprehensive inspection of 7 & 8 May 2014 we received information about concerns in relation to the service. As a result we carried out a focused inspection on 12 September 2015. The concerns were about people being woken and got up from 4am, staffing levels within the service and moving techniques used by staff. We also received concerns about the cleanliness of the environment and people not being attended to in an appropriate time, with call bells being left unanswered.

This report only covers our findings in relation to these topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Vicarage Residential Home on our website at www.cqc.org.uk.

Vicarage Residential Home is registered to accommodate a maximum of 35 older persons. They provide residential care without nursing. Nursing is provided from the community nursing team as required. There were 35 people living at the service when we visited. The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We visited early in the morning, from 5.45 a.m. until 9.30 a.m. and found six people already up and dressed and the two care staff on duty assisting a seventh person with personal care. Staff confirmed they had received manual handling training.

People were observed to have call bells within reach. As staff were busy with people who required two staff to assist them, other people needed to wait for assistance. One person said; "I'd love a cup of tea but have to wait until breakfast." They said this was because staff were busy in the morning.

People's care records held information about how people wished to be supported. However for people who were unable to give consent we did not find information recorded on the time they liked to get up in the morning.

Summary of findings

People were in a service that was clean and maintained.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe.	Requires improvement	
People were not receiving appropriate care and treatment to meet their needs.		
There were insufficient numbers of staff to keep people staff at night.		
The home was clean and maintained.		



Vicarage Residential Home 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 was 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.

We undertook a focused inspection of Vicarage Residential Home on 12 September 2015. This inspection was completed after concerns were raised. We inspected the service against one of the five questions we ask about services: is the service safe? This is because the concerns raised were in relation to this question.

The inspection was undertaken by one inspector and was unannounced.

Before our inspection we reviewed the information we received held about the home including the concerns raised with the Care Quality Commission (CQC).

During the inspection we spoke with eight people who lived there and six members of staff.

At the visit we looked at three people's care records, staff duty rotas and other records.

Is the service safe?

Our findings

Following the service's comprehensive inspection, we received information of concern about people being woken up and got out of bed from 4am, staffing levels within the service and safe moving techniques used by staff. We also received concerns about the cleanliness of the environment and about people not being attended to in an appropriate time, with call bells being left unanswered.

People's care was not always appropriate for their needs. On arrival at the home at 5.45 a.m. we found six people already washed, dressed and sitting in the lounge or their bedroom. We spoke to six members of staff and some staff confirmed that they started to get people up at either 4am or 5am. We were informed the routine was to start with people who required two staff to assist them, for example people who needed a hoist to move safety. No information was recorded in care plans that these people, who were unable to agree, wished to get up that early. One person said; "I like to get up early." When they were informed of the time said; "Oh, that's a bit early."

Staff confirmed they had received training to move people safely. We observed staff assisting someone dressing and staff informed the person what they were going to do at each step to reassure them.

People said they had to wait longer for assistance in the morning. Two staff members were assisting people with personal care needs. Due to the level of need of the people they were assisting, requiring two staff to keep them safe, other people were left without staff observation. One person said; "I'd love a cup of tea but have to wait until breakfast as staff are busy." People now had a new call bell system in place which showed how long people were waiting for assistance. We saw people had access to call bells. We observed the staff responding as quickly as possible. However, responding to the bells sometimes meant that people who required two staff for assistance were only left with one. Staff did ensure people were safe before leaving.

We saw documentation where staff noted which people had received personal care before they finished duty. The report for night staff showed some days 12 to 15 people had been attended too. However, we received conflicting information about what this report recorded. Care staff confirmed it recorded who was washed and dressed by the time the night staff had finished their shift. However the senior staff said it recorded people who had received some personal care intervention only but were not necessarily up. The registered manager confirmed, after the inspection, that this book was to record people who had received personal care and not got out of bed.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were kept safe by a tidy environment. All areas we visited were clean. Domestic staff were responsible for the cleaning and there checklists for night staff to provide additional support. Protective clothing, such as gloves, were readily available throughout the home to reduce the risk of cross infection. Staff understood the importance of following infection control procedures.

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care
	Regulation 9 (1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care.
	People were not receiving appropriate care and treatment to meet their needs.