Aegis Residential Care Homes Limited

The Old Vicarage Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 19, 26 and 27 April 2017. After that inspection, we received information of concern in relation to lack of confidence in management; poor falls management, risk assessment and care recordkeeping; inadequate personal care; lack of effective infection control measures; insufficient staffing levels and poor training provision; lack of nutritional support; and people's preferences not being met. As a result, we undertook a focused inspection to look into those concerns. However, we decided to extend this to a comprehensive inspection because we found additional concerns during this focused inspection.

The Old Vicarage provides personal care for a maximum of 35 older people who may be living with dementia or a physical disability. The home is situated in a residential area of Freckleton village close to local shops and other amenities. There is full lift access to both floors to assist people with reduced mobility. Communal areas consist of a lounge, dining room and rear garden.

A registered manager was not in place. 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.

At the last inspection on 19, 26 and 27 April 2017, we rated the service as Requires Improvement. This was because breaches of legal requirements were found. The provider failed to ensure systems were in place to assess, monitor and improve the quality and safety of the service. These had not been established and operated effectively and records were not consistently accurate.

We additionally made recommendations for the provider to further improve people's safety and welfare. These concerned systems to enhance safe medication recordkeeping, falls management, general risk assessments and staff training. We also recommended the provider developed their person-centred approach to care planning.

During this inspection, we found the provider continued to fail to maintain good governance and oversight at the home. Audits we looked at did not pick up the concerns we found during our inspection. Care records and monitoring systems were poorly organised and the management team failed to store them securely. We noted gaps in care records and people's documented preferences were not consistently followed. We reviewed the management team's staffing tool and found it did not always meet the requirements of people's complex needs. Although people's feedback was sought, the provider had not always followed identified concerns through. This is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

You can see what action we told the provider to take at the back of the full version of the report.

Staff told us the management team were supportive in their work and personal issues. They felt a part of the drive to improve the home and were keen about developing the Old Vicarage further.

We found the provider had improved falls assessment and management processes. For example, they introduced new systems, which covered an outline of the accident, body mapping of any injuries and ongoing observation charts. Falls risk assessments were implemented to identify hazards and actions to reduce them. We noted one person's fall was not properly documented and the management team assured us they would address this through staff training.

You can see what action we told the provider to take at the back of the full version of the report.

We noted staffing levels and skill mixes were insufficient and the deployment of employees was not always effective. For example, people's meals were disrupted because there were not enough personnel to support them. We observed they had to wait to be supported with personal care. There were not enough trained staff to manage people's medicines at night. A relative commented, "Staffing levels are horrific. Many times I've gone round looking for staff." This is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing.

You can see what action we told the provider to take at the back of the full version of the report.

We found care records contained medication risk assessments and care plans, and staff administered recorded medicines safely. However, there were not always medication trained staff available 24 hours a day to monitor for potential side effects. People received their medication, including night sedation, too early in the evening. If they needed something during the night, the system in place was poor medicines management because there were potential delays in people's treatment. This is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

You can see what action we told the provider to take at the back of the full version of the report.

On arrival, we looked around the premises and found multiple areas of concern with infection control practices. Carpets, furnishings and linen were dirty and stained and associated cleaning records had not been fully completed. We found a very strong odour throughout our inspection and people were dressed in stained clothes that were not changed. This is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

You can see what action we told the provider to take at the back of the full version of the report.

We found care plans contained detailed information about each person and their requirements. This guided staff, especially new employees, to people's needs and their wishes about their support. We observed staff assisted those who lived at the home with compassion and courtesy. A relative said, "The staff are very kind to me."

However, we saw people's choices were not always followed. For example, a relative said their family member preferred female staff to support them with personal care, which was not consistently provided. We found missing information in records, such as fluid and food monitoring forms where there were gaps for hours at a time. This meant oversight of people's needs was incomplete and inconsistent, which negatively affected the responsiveness of care delivery.

The cook ensured special diets, such as for medical conditions, allergies and soft meals, were catered for.

However, two staff simultaneously supported three individuals who required assistance, which meant their meals were constantly disrupted. We received mixed comments about the quality of food provided.

Staff demonstrated a good understanding of protocols and reporting procedures related to safeguarding incidents. Training records we looked at confirmed they had completed relevant training.

Staff files we looked evidenced staff received training relevant to their roles. The management team reviewed potential employees' full employment history and obtained required checks to ensure they recruited appropriate staff. This was followed by in-depth induction to support them in their new roles.

Staff demonstrated a good level of awareness of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Where people were deprived of their liberty to safeguard them, we found up-to-date records were in place. The person who lived at the home or their representative had signed their agreement to each area of their support plans.

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.

Staffing levels were insufficient to meet people's complex needs whilst completing other tasks, such as medicines administration. People were not always assisted by staff who were well rested.

Not all night shifts were covered by staff who were fully trained and competency tested to administer medication.

The management team failed to ensure consistent and safe management of infection control practices.

New risk assessment forms were more detailed to better manage potential risks.

We saw evidence staff received training related to the protection of people from potential abuse or poor practice.

Staff files held evidence to demonstrate the management team had followed safe procedures to recruit appropriate staff.

Is the service effective?

Requires Improvement

The service was not always effective.

Care records we looked at held nutritional risk assessments and monitoring forms to protect people from the risk of malnutrition. However, people's needs were not always met with a timely approach because staff were poorly deployed at mealtimes.

We found the provider had implemented a range of training to support staff in their roles and responsibilities.

The management team had ensured recoded consent to care and treatment was in place. Staff received training to develop their understanding of principles related to the MCA and DoLS.

Is the service caring?

Good

The service was caring.

We observed when staff interacted with people they used a soft, kind and caring approach.

Whenever staff supported people, we saw they did so in ways that maintained their dignity. They had a good awareness about the importance of maintaining people's self-reliance.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Although people told us staff were responsive to their personalised needs, we found their recorded preferences were not always followed.

We noted care plans contained detailed information to guide staff to people's support requirements. However, we found gaps in records and missing information. Staff could not be assured approaches to people's care were currently meeting their needs.

We found the provider was continuing to make improvements to the provision of activities at the home.

The provider kept a complaints log to show details of concerns raised, actions taken and outcomes to completed processes.

Is the service well-led?

Requires Improvement

The service was not always well-led.

We found continued concerns with the governance and oversight at the home. Systems and records failed to pick up concerns we found at our inspection and were poorly organised.

We found the provider encouraged people and their relatives to give feedback about the quality of the service. However, their concerns were not always followed through and reviewed.

Staff told us they felt a part of the ongoing service improvement and their thoughts and suggestions were sought.

The Old Vicarage Care 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 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.

We received information of concern in relation to poor care provision at the Old Vicarage. As a result, we undertook a focused inspection to look into those concerns. However, we decided to extend this to a comprehensive inspection because we found additional concerns during this focused inspection.

The inspection visit at The Old Vicarage was undertaken on 17 and 18 August 2017 and was unannounced. The inspection team on the first day consisted of two adult social care inspectors and an assistant inspector. On the second day of the inspection, there was one adult social care inspector.

Prior to the inspection, we reviewed the information we held about The Old Vicarage. This included notifications we had received from the provider. These related to incidents that affect the health, safety and welfare of people who lived at the home.

We found not all of those who lived at The Old Vicarage were able to communicate fully with us. Therefore, during our inspection, we used a method called Short Observational Framework for Inspection (SOFI). This involved observing staff interactions with people in their care. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We walked around the home and spent time observing the interactions between people, visitors and staff. We spoke with a range of people about The Old Vicarage. They included six people who lived at the home, seven relatives, three members of the management team and five staff members. We further discussed care with a visiting healthcare professional. We did this to gain an overview of what people experienced whilst

living at The Old Vicarage.

We looked around the building to check environmental safety and cleanliness. Furthermore, we looked at a range of records. These included documents in relation to seven people who lived at the home and four staff files. We reviewed records about staff training and support, as well as those related to the management and safety of The Old Vicarage.

Requires Improvement

Is the service safe?

Our findings

Before this inspection, we received information of concern in relation to poor falls management, risk assessment and care recordkeeping; lack of effective infection control measures; and insufficient staffing levels.

We looked at staffing rotas, people's complex needs, observed care delivery and assessed how staffing levels were checked. We found the number and skill mix of staff was not always sufficient to meet people's support plan requirements. One person told us, "I asked to go the loo. I've asked three times, but I've still not been." Six people needed two staff to help them with personal care, whilst others had behaviour that challenged the service. Normal staffing numbers to cover daytime from 08:00 to 20:00 were four care staff. We saw this was reduced to three staff at the weekends from 15:00 to 20:00. This was insufficient to meet people's complex needs and carry out other duties, such as medicines administration. A staff member said, "There's not always staff available to help residents go to the toilet or have something to eat or drink." Another staff member stated, "I think we can do with more staff. We don't always have a lot of time to chat with people."

We further observed shifts covered by regular agency staff who were familiar with people who lived at the home. However, we looked at the previous four weeks and forthcoming two weeks' rotas and found staffing levels were not consistent. There were only three care staff during the evenings of eights shifts and only three staff in the morning of one shift. A staff member said, "We definitely need more staff. Everything gets done, but it would be better for cover if someone is off sick." Variable staffing levels impacted upon people's care because the management team could not assure needs were constantly and fully maintained. A relative stated, "I'm concerned about the care they are not giving. They are doing their best, but there isn't enough staff on duty to do it." The management team were not always able to fully focus upon their roles because they were frequently included in care provision. Another staff member commented, "It's quite hectic at times because it is understaffed. We sometimes are rushing people, which makes them uncomfortable."

There were two employees to support people from 20:00 to 08:00. Not all staff had completed their medicines training and competency testing, which meant 24-hour cover with trained employees was not always available. Ancillary staff had been trained to provide care and were able to cover shifts. However, this took them away from their normal roles, such as housekeeping, which negatively impacted upon the quality of care. Additionally, staff worked long hours and multiple shifts in a row. For instance, one employee worked 72 hours and covered six shifts consecutively during the week. One staff member told us in order to cover medication rounds, "I have worked 60 to 80 hours per week." We observed people had to wait to be supported with their lunch because staff were poorly deployed. One person commented, "The staff are very busy. They could do with more." Another person said, "There's not many staff here. They have a lot to put up with."

This is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the management team failed to ensure consistent staffing levels and skill mixes were available to meet people's requirements.

At our last inspection on 19, 26 and 27 April 2017, we found the provider had made improvements to medicines management. We requested they continued to enhance auditing and safe medication recordkeeping. This was because staff did not always follow their protocols on medicines charts and with 'when required' medication. The management team had not completed checks of the medication fridge temperature. Therefore, they could not be assured this was working properly.

During this inspection, we found the management team had addressed these concerns. For example, staff documented regular, up-to-date medication fridge temperatures and completed frequent audits. We observed recordkeeping followed protocols established at the home.

However, we found not all night shifts were covered by staff who were trained and competency tested to administer medication. Trained staff members completed medicines rounds every day by starting shifts at 06:30 and before the end of their shift at 19:30. Consequently, people received their medication, including night sedation, too early in the evening. The area director told us staff who lived nearby were on call and available during the night if an individual needed something. This included medication to assist with breathing and 'when required' tablets. This is poor medicines management because there would be a delay in people's treatment. Additionally, there were not always trained staff available 24 hours a day to monitor for potential side effects.

When we discussed this with the management team, they were unable to explain why they had not safely managed associated risks. They failed to demonstrate why 24-hour cover from suitably qualified staff was not always in place. The management team were not able to clarify why their systems did not protect people from receiving their medicines with a timely and accurate approach. There were no risk assessments in place to safeguard those who lived at the home from the potential risks related to their current procedures.

This is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the management team failed to provide adequate numbers of trained staff 24 hours per day.

We reviewed people's medicines records and found staff completed them correctly. For example, there were no missing signatures. Care records held medication risk assessments and care plans, which covered actions to support people and control measures to reduce potential risks. We noted records contained each person's photograph to reduce the risk of them receiving the wrong medication. We observed a staff member administered medication by focusing on one person at a time. They explained to people the purpose of their medicines and provided a drink to take them. They completed records after administration to confirm people had taken their medication. The staff member ensured the storage trolley and cupboards were locked when not in use. We saw controlled drugs were kept secure in line with the Misuse of Drugs Act 1971 (Regulations 2001).

On arrival, we looked around the premises and found multiple areas of concern. There was a very strong odour, which did not dissipate during the day. This continued during the second day of our inspection. A relative told us, "We've noticed the smell has got better here, but there's still a malodour." The sluice sink was stained and dirty and the back stairs carpet had debris along with extensive damage to the wallpaper. The first floor shower room tiles were ingrained with grime and clinical waste and pads were left on people's floors. During the morning of the first day of our inspection, we saw the lounge carpet had evidently not been vacuumed. This was because there were slug trails in the area of one of the windows, which had not been attended to before we left.

Bedroom furniture and mattresses were stained and beds were left unmade throughout our inspection. We

saw people were in bed with dirty linen, such as faecal and urine stains. One bed was made up, but still contained food crumbs and blood stains under a quilt. Staff had put a cover over one quilt that smelt of urine and was still damp. Plates of half-eaten food were left for long periods bedrooms. The dining room bin was overflowing with used, disposable aprons. This was not attended to between our arrival and 13:00 when we flagged it with the management team.

Staffing rotas we looked at evidenced housekeeping staff were not always available to maintain a clean environment. Although they were trained to provide support for people, we saw the housekeepers were frequently utilised in care provision. This had a negative impact upon safe infection control measures. Toilet cleaning records were not completed every day to evidence required tasks had been completed. The service's infection control audit did not pick up the multiple concerns we found during our inspection.

We observed people were dressed in dirty or stained clothes. On arrival, we saw one person had recent spillages on their top. Before lunch, we noted staff had addressed this by putting a jumper on over the stained garment. This did not meet good standards of infection control or maintain the individual's dignity and wellbeing. A relative told us, "I can smell [when my relative] isn't clean. I wash her clothes and can tell they're not clean."

This is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the management team failed to ensure consistent and safe management of infection control practices.

Following our last inspection on 19, 26 and 27 April 2017, we made a recommendation the provider implemented best practice guidance related to falls management. This was because risk assessments did not always give clear guidance to staff about how to manage people's safety.

At the time of our inspection, the local safeguarding authority told us they were investigating an accident. This was about staff not following their protocol and the incident was not recorded. We reviewed the provider's falls management procedures and associated documentation. They undertook a post falls assessment tool, which covered an outline of the accident, body mapping of any injuries and ongoing observation charts. This was underpinned by a falls risk assessment to identify any hazards and control measures to reduce potential risks. Although records were fully completed, we noted one person's fall was not properly documented. When we discussed this with the management team, they assured us they would address this as a priority through staff training.

The management team showed us new risk assessment forms they were implementing. We saw these were more detailed to assist staff to understand and better manage potential risks. They covered, for example, legally authorised restrictions to freedom, falls, medication, nutrition and continence management. Information included control measures and review of the effectiveness of the assessments. We noted the management team were in the process of transferring those who lived at the home over to the new system. We were unable to fully assess the impact this would have on the protection of people against potential risks of receiving care. However, the management team assured us this was an ongoing development, which we will check at our next inspection. A person who lived at the home told us, "They're all very good here, I feel safe."

Following our last inspection on 19, 26 and 27 April 2017, we made a recommendation the provider introduced best practice guidance related to safeguarding reporting. This was because the management team had not, where required, referred incidents to the local authority.

During this inspection, we found the management team worked openly with the local authorities as part of their improvement requirements. Additionally, they submitted notifications to CQC about incidents that affect people's safety and wellbeing. This helped us to have clear oversight about how the provider managed incidents that occurred at the home. We saw evidence staff received training related to the protection of people from potential abuse or poor practice. They showed a good understanding of related protocols and reporting procedures. One staff member told us, "if I had any concerns I'd go straight to the person in charge and ring safeguarding."

Staff files we looked evidenced the management team followed safe procedures to recruit appropriate staff. This included references and criminal record checks obtained from the Disclosure and Barring Service (DBS), as well as reviewing the applicant's full employment history. Staff confirmed their recruitment was thorough and professional to ensure they were safe to work with vulnerable people. One staff member said, "I can confirm I didn't start until I got my DBS and references." Employment was followed by an extensive induction training programme to help staff understand their role and develop their skills. Another staff member told us, "I've never had this training before at other homes. It was such a good change and I wanted that. I want to do my job properly." A person who lived at the home added, "The new staff seem fun and caring."

Requires Improvement

Is the service effective?

Our findings

Before this inspection, we received information of concern in relation to poor care recordkeeping; inadequate personal care; insufficient training provision; and lack of nutritional support.

We observed staff were poorly deployed at lunchtime because there were not enough of them to meet everyone's support requirements. For example, people had to wait for their requests, such as for drinks, to be met because staff were engaged in other tasks. Two staff simultaneously supported three individuals who required assistance, which meant their meals were constantly disrupted. We observed one person had their main course and pudding untouched in front of them until staff could help them. Consequently, they started to eat their meal when it was no longer hot. We also saw another person pressed their call bell several times. They told us, "I've been waiting for ages. Four staff have ignored me. I want my breakfast. Where the hell is my breakfast?" A visiting professional commented they observed there was not always enough staff to support people with their nutritional requirements.

Care records we looked at held nutritional risk assessments and monitoring forms to protect people from the risk of malnutrition. The documentation covered actions to support people and control measures to follow in order to reduce potential risks. The cook ensured they catered for special diets, such as for medical conditions, allergies and soft meals. They completed other records to evidence safe food hygiene practices, such as cleaning schedules and various temperature checks. The Food Standards Agency had awarded The Old Vicarage their top rating of five following their last inspection. This graded the service as 'very good' in relation to meeting food safety standards about cleanliness, food preparation and associated recordkeeping.

We found care plans related to nutritional support included people's food preferences, which the cook retained a copy of in the kitchen. This meant their nutritional intake was likely to increase because they ate what they preferred. Additionally, we saw a varied menu programme with additional options ensured people had a choice of what to eat. We received mixed comments about the quality of food provided. For instance, a person who lived at the home told us, "I love my food. The meals here are great and I have lots of choice." Another person said lunch was, "Gorgeous." However, a third person commented, "It's horrible." Another individual told staff they did not enjoy their meal. We noted the management team did discuss and review menus and food options with people who lived at the Old Vicarage through regular 'resident' meetings.

During our last inspection on 19, 26 and 27 April 2017, we saw there were gaps in the training of staff. When we discussed this with the management team, they showed us evidence of a wide range of training planned throughout the forthcoming months.

During this inspection, we found the provider had implemented a range of training to support staff in their roles and responsibilities. This included, for example, fire safety, movement and handling, first aid, safeguarding, infection control, dementia care, policies and communication skills. A staff member told us, "We do a whole training pack, which is good for my work." Another staff member added, "I was quite

surprised at how much I didn't know."

We saw evidence staff received regular supervision to underpin their roles and responsibilities. Supervision was a one-to-one support meeting between individual staff and their line manager to review their personal and professional progress. A staff member said, "I'm having my supervision today. The managers are supportive and would give us any extra training we asked for."

Care records we looked at contained information about professional healthcare visits and appointments. This included GPs, district nurses, opticians and social workers. Documentation covered detailed communication about outcomes of visits/appointments, checks that care plans were updated and relatives were informed. However, a visiting healthcare professional commented people did not always get effective care because staff had not consistently followed up on their instructions. They gave an example of setting up a bathing plan for one person who lived at the home, which staff had not always carried out. Information the management team showed us, including bathing records, were disorganised and did not give clear oversight of these concerns. It was difficult for us to assess if people had a bath or shower when they wanted one because sheets were missing.

We found the management team had ensured recorded consent to care and treatment was in place. The person who lived at the home or their representative had signed their agreement to each area of their support plans. One person said, "They never take over. They respect me. I'm 92 so I deserve that." We observed staff checked people's consent before assisting them and explained what they were going to undertake. A staff member told us, "I always ask what they want to wear and help them to choose whatever we are doing before we go ahead."

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Where people were deprived of their liberty to safeguard them, we found up-to-date records were in place. These included applications to legally restrict people's liberty, confirmation of authorisation and mental capacity assessments. Staff received relevant training and had a good level of awareness about the MCA. One staff member explained, "Sometimes residents refuse a bath or shower. We can't force them because it's against their wishes." Staff we spoke with said they received additional relevant training to strengthen their skills. This covered, for example, providing inclusive support and helping people to make risky decisions appropriately.

Good

Is the service caring?

Our findings

Before this inspection, we received information of concern in relation to poor care recordkeeping; inadequate personal care; and people's preferences not being met.

We observed staff interacted with each person with kindness and respect and people confirmed this when we discussed staff attitude with them. One person told us, "I shall get very angry and upset if someone tried to move me. This is my home and I wouldn't want to live anywhere else." Another person added, "Staff are marvellous and very kind." A relative commented, "Staff are very friendly and do their best." A staff member stated, "I'm proud of my work and the Old Vicarage."

We observed when staff interacted with people they used a soft, kind and caring approach. For example, they knelt down and made good use of eye contact and touch. They encouraged the person whilst supporting them, making appropriate use of humour. One person who lived at the Old Vicarage said, "The staff are kind and loving." Staff demonstrated a good understanding of the principles of good care. One staff member told us, "It's about building a rapport with people and looking at what interests them."

Staff respected individuals and ensured their privacy was maintained. For example, we noted they knocked on bedroom and bathroom doors before entering. We found care plans contained detailed information about each person and their requirements. This guided staff, especially new employees, to people's needs and their wishes about their support. One new staff member told us, "I've had a look at the care plans and I know how people like to be helped. Working with the other staff is also helping me to get to know each resident's individual care."

Whenever staff supported people, we observed they did so in ways that maintained their dignity. For example, they spoke in soft, quiet tones. One person told us, "It's a pleasure living here." When we discussed values relevant to maintaining people's dignity with staff, they showed a good level of awareness. A staff member told us, "You need to be caring gentle and kind. Remember to respect them like your own family."

Documentation we viewed evidenced staff had supported people to maintain their human rights. For example, they recorded each person's spiritual wishes and how important this was to them, such as whether they were still practising. Care planning included details such as, 'To promote choice and independence at all times.' Staff received equality and diversity training to enhance their understanding. We further noted documented details about people's preferences and backgrounds, which evidenced they and their relatives were involved in their care planning. A staff member told us, "We try to encourage the residents to be involved as much as possible. We help them to be a part of the home and be with other residents."

Staff demonstrated a good awareness about the importance of maintaining people's self-reliance in relation to their welfare. This was because the management team had recorded a good level of relevant information in each individual's care records. One person told us, "I'm fiercely independent and the staff help me to stay that way."

Staff and the management team helped family members to maintain their important relationships. For instance, they moved two people who lived at the home and were related to each other to bedrooms closer together. This was with each person's request and enabled them to have more time together, such as having meals jointly in one of their bedrooms.

Requires Improvement

Is the service responsive?

Our findings

Before this inspection, we received information of concern in relation to poor care recordkeeping and people's preferences not being met.

People and relatives told us staff were caring and responded well to meet their needs. One person said, "The staff come and have a chat when they have a moment. They are very caring." A relative added, "I feel [my relative's] care needs are being met." A staff member stated, "I love my job. It's wonderful seeing the residents respond in a positive way when I'm doing activities with them."

At our last inspection on 19, 26 and 27 April 2017, we found the provider did not always keep consistently accurate and up-to-date records. Care records did not always contain information that was personalised to each person's individualised needs. People and their relatives told us they were not consistently involved in the review of their care planning. Where changes in their support occurred, staff had not updated their records to meet their ongoing needs. Monitoring charts had gaps or were not up-to-date to ensure staff had accurate information to deliver care safely.

This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

During this inspection, we found care files we viewed had documentation about each person's preferences. This included their spiritual requirements, whether they wished to have their door left open, personal care choices, activities and bed times. Other information included an outline of the person's life history and significant others important to them. This gave staff guidance to assist them to gain an understanding of people's backgrounds and personalised support requirements. A staff member confirmed, "I've had the time to get to know the residents, what their needs are and what interests they have."

However, we saw this was not always followed because a relative said their family member preferred female staff to support them with personal care. Rotas we looked at showed not all night shifts included female employees. One staff member added, "Sometimes there are two male carers on at night. Some residents don't want male carers. Where's their choice in this?" Furthermore, bathing records we were shown were disorganised and we saw their were missing sheets. It was difficult for us to assess if people had their choice of bath or shower when they wanted one. A relative commented to us, "I don't feel [my relative] is showered or bathed as regularly as should be." When we discussed this with the management team, they recognised inconsistencies in their current systems. They said they understood skill mixes and oversight of people's preferences did not always assure choice was continuously met.

Additionally, we found gaps in records and missing information. For instance, staff had not followed their falls protocol because they had not completed and accurately documented a falls incident. Fluid and food monitoring forms were not fully recorded because there were gaps of hours at a time. This meant oversight of people's needs was incomplete and inconsistent, which negatively affected the responsiveness of care delivery. We saw care plans were not always reviewed with a timely approach. For example, one individual's

eating and drinking support plan had not been reviewed since 03 December 2015. Therefore, staff could not be assured approaches to people's care were currently meeting their needs.

This is a continued breach of regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider failed to ensure completed records continuously informed staff about each person's requests and requirements.

Records held evidence to demonstrate people had their needs assessed before admission and on an ongoing basis. For example, the management team checked each person's requirements in relation to communication, mobility, personal care, medication, pressure area care and nutrition. Assessments were updated monthly to provide oversight of the responsiveness of approaches to people's support.

We found the provider was continuing to make improvements to the provision of activities at the home. This included group and one-to-one support intended to improve people's stimulation, social skills and wellbeing. The management team had recently recruited an activities co-ordinator who worked every weekday to support those who lived at the home to keep occupied. They told us, "I am doing one-to-one stuff at the moment with each resident who wants that, so they have all that during the week along with group activities." External entertainers provided music and sing-a-longs and a new knitting circle had been set up at the Old Vicarage. Other activities included one-to-one or group games, physical exercise, health and pampering, painting, crafts, skittles, bowling competition and football. A relative stated, "The new activities co-ordinator appears very good."

We found corridor walls held multiple tools to provide stimulation and reminiscence therapy for people who lived with dementia. These included a post box area; a workstation with various plugs, wires and other objects; and a display about flowers and plants. However, throughout our inspection we did not observe staff encourage or support people to utilise these valuable devices. When we discussed this with the management team, they agreed these tools were underused. They told us they would better implement them to enhance people's wellbeing. The activities co-ordinator stated they were developing a spreadsheet for the management team to review on a weekly basis. They added, "It identifies what people have done and we can then start to incorporate that in their care plan."

The provider had received formal complaints in the last 12 months. We reviewed two in order to assess recordkeeping and whether the management team followed their related procedures. The management team kept a complaints log to evidence details of the concerns raised, actions taken and outcomes to completed processes. We saw positive resolutions to the complaints we looked at, which were responded to with a timely approach. 'Residents' Handbooks' were available in each person's room to inform them about how to complain, as well as how concerns would be dealt with.

Requires Improvement

Is the service well-led?

Our findings

Before this inspection, we received information of concern in relation to lack of confidence in management, as well as systems and practices in relation to the quality of care people received.

Although a registered manager had not been in place since May 2016, we saw evidence the provider had attempted to recruit a suitable applicant. However, although successful candidates had been recruited, they then left shortly afterwards to start employment elsewhere. A new manager commenced their post at The Old Vicarage on 14 August 2017 and was in the process of completing their induction and registration with CQC.

During our last inspection on 19, 26 and 27 April 2017, people and relatives said they found their care and the home's leadership was improving. However, during this inspection, a person who lived at the Old Vicarage told us they had been waiting a long time for their breakfast. They added, "This place is getting worse." Another individual commented, "It's hopeless here." A relative discussed with us the home's management and stated, "It's been turmoil since [a previous registered manager] left. No communication whatsoever. They don't tell us anything and we haven't been introduced to the new manager."

At our last inspection on 19, 26 and 27 April 2017, we found the provider's systems to assess, monitor and improve service quality and safety had not been established and operated effectively. We saw the accident and incident audit was ineffective because it had not identified if further action was required in relation to safeguarding referrals. Additionally, the provider did not always keep consistently accurate and up-to-date care records.

This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

During this inspection, we found further concerns with the governance and oversight of the Old Vicarage. The main office and auditing systems were disorganised and when we asked for required documents, the management team were not always able to locate them. Information available had missing records and files were disordered. Consequently, quality assurance and good system-wide governance was not always in place to provide efficient monitoring of care delivery.

The provider had implemented a range of audits to check, for example, complaints, safeguarding, CQC notifications, deaths and pressure ulcers. However, we found multiple concerns with infection control practices and care records that were not identified by the related audits completed by the management team. For example, they documented issues found in relation to care plans would be dealt with through the new electronic system. However, this was not going to be implemented for several weeks and there was no interim measure to address concerns we found. The medication audit showed there were not enough staff trained to administer medicines at night and training was ongoing. Nevertheless, we saw night shifts were covered by staff who had not completed their competency testing and were not safe to monitor people who received medication.

We looked at the management team's staffing tool and found it did not always meet the requirements of people's complex needs. For example, there was no clear evidence to show how the management team reached decisions about the level of support each person required. We observed six people needed two staff to assist them. This meant there were not always enough personnel to carry out other tasks whilst continuing to monitor everyone who lived at the home.

When we walked around the building, we found care records were not safely stored. We saw these were kept in the staff changing room situated next to a person's bedroom and with an external exit. The doors to this area were left open, which meant anyone could freely access people's confidential information.

Care records we looked at were not always fully completed. For example, one person's wounds were body mapped, but there was no further information about how this should be managed. We noted another individual's fall was not properly documented and staff had not followed their related recordkeeping protocol. People's recorded preferences were not consistently followed because female staff were not always available to provide personal care where this was requested. A visiting healthcare professional told us they found the vast majority of the time staff did not follow documented care instructions. They added this resulted in a deterioration of one person's wounds. The care plan quality audit the provider showed us did not pick up the concerns we found.

We found the management team encouraged people who lived at the home and their relatives to give feedback about the quality of the service. This included satisfaction surveys and we reviewed a sample of these. We noted feedback was mixed, for example, one relative commented they found the home, 'Still a bit smelly.' On the other hand, another relative stated, 'Things are definitely improving. Thanks so much, such a relief.' We looked at how the provider took action to address negative comments about care delivery. For instance, they dealt with one relative's concerns related to pad changes. However, we found a strong odour permeated throughout the home, which did not dissipate during our inspection. This showed people's concerns were not always continuously followed through and reviewed.

These are a breach of regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider continued to fail to have good oversight and organisation of systems and records.

The management team held regular relatives' meetings to check if they had any issues or suggestions to improve the Old Vicarage. We looked at the minutes from the last meeting and saw identified action points were prioritised, along with set due dates. For example, relatives highlighted they felt activity provision needed to be developed and we saw the management team had consequently recruited an activities co-ordinator.

Staff we spoke with said the management team were supportive with their work and personal issues. One staff member told us, "When I applied I said I had some childcare issues and they've been very accommodating with that." Other staff confirmed the management structure was good and they were looking forward to working as a strong team under the new manager. A staff member told us, "We are a new team, but we're working well together and with the new manager I hope we can all get to where we need to be as quickly as possible." Another staff member commented, "I like it here, the staff are good and the managers are really supportive." A third staff member stated, "The managers are very supportive. They're the best managers I've worked for."

The management team held three team meetings in the previous seven months. We looked at the minutes from these meetings and found staff had the opportunity to raise concerns or ideas about the home's improvement. Staff told us they felt a part of the ongoing service improvement and their thoughts and

suggestions were sought. One staff member confirmed, "We all know it needs to improve, but I really want to be a part of that drive." Another staff member told us they were aware the Old Vicarage required improvement before they started in post. They added, "It's a bit unnerving, but I'm really keen to work with everyone to get things up to scratch."

We found the provider had implemented effective systems to assess and monitor environmental and fire safety. For example, window restrictors were in place to protect people from potential harm. The home's legionella, gas and electricity safety certification was up-to-date. The fire risk assessment and safety checks were regularly reviewed and alarm systems were frequently serviced. Staff documented water temperature checks to confirm these were in line with national health and safety guidelines. Hot, running water was not always available throughout the home. However, the management team were already aware of this issue and attended to this within 24 hours of our inspection.

The service had on display in the reception area of the home their last CQC rating, where people who visited the home could see it. This is a legal requirement from 01 April 2015.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The management team failed to provide adequate numbers of medication trained staff 24 hours per day. People received their medication, including night sedation, too early in the evening. Regulation 12 (1), (2) [a, b, c, g] The management team failed to keep up-to-date cleaning records to evidence tasks had been completed. There was a very strong odour that permeated throughout the home and did not enhance people's wellbeing. Carpets, furnishings and linen were dirty and stained. People were dressed in stained clothes that were not changed. Regulation 12 (1), (2) [a, b, h]

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider continued to fail to have good oversight and organisation of systems and records. The provider failed to ensure completed records continuously informed staff about each person's requests and requirements. Regulation 17 (1), (2) [a, b, c, d (ii), e, f]

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The management team failed to ensure consistent staffing levels and skill mixes were available to meet people's requirements. We observed people had to wait to be supported by staff who were not always well rested. Levels were insufficient to meet people's complex needs whilst carrying out other duties, such as medicines administration.

Regulation 18 (1)