Central England Healthcare (Stoke) Limited

The Old Vicarage Nursing 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 responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

We inspected to look for improvements following our previous inspection in March 2016 where we had found several breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to people not receiving care that was safe, effective, responsive or well led. The provider had been sending us weekly action plans informing us how they planned to improve and their progress towards these plans. We undertook this focused inspection on the 27 September 2016. This report only covers our findings in relation to the areas of concern. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Old Vicarage Nursing Home on our website at www.cqc.org.uk.

The Old Vicarage provided accommodation and nursing care to up to 45 people. At the time of this inspection 35 people were using the service.

The previous manager had left and a new manager was in post who was in the process of registering with us. 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 legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were not always safeguarded from potential abuse as the provider was not following the local authority safeguarding procedure by ensuring that all incidents of suspected abuse were reported and investigated.

The provider was still not consistently follow the principles of the MCA 2005 to ensure that people consented to or were supported to consent to their care, treatment and support.

The systems the provider had in place to monitor and improve the service were ineffective as not all the required improvements had been made since our previous inspection and as stated in the provider's action plan.

People were cared for by staff who were supported and trained to fulfil their roles. There were sufficient staff to meet people's needs safely.

People's nutritional needs were met and when their health care needs changed or they became unwell advice and support from other health care professionals was gained.

People's medicines were stored and administered safely. However records relating to reviews of people's medicines were not up to date.

People received care that was personalised and reflected their individual preferences. People were encouraged to be participate in hobbies and activities of their choice.

People and their relative's views were sought on the quality of service they received through regular reviews, meetings and surveys.

The provider had a complaints procedure and people and their relatives knew how to use it. Complaints were managed according to the procedure.

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 consistently safe.

People were not always protected from abuse and the risk of abuse.

Risks to people were assessed and minimised, however risk assessments were not always up to date.

There were sufficient staff to safely meet the needs of people who used the service.

People's medicines were stored and administered safely. However records relating to reviews of people's medicines were not up to date.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The provider did not always follow the principles of the MCA and ensure that people consented to or were supported to consent to their care.

People were cared for by staff who were supported and trained to fulfil their roles.

People's nutritional needs were met.

People received heath care when their needs changed or they became unwell.

Is the service responsive?

Good

The service was responsive.

People were receiving care that was personalised and met their individual needs and preferences.

People were encouraged to be involved in hobbies and activities of their choice.

The provider had a complaints procedure and people and their relatives felt able to complain if they needed to.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Further improvements to people's care, treatment and support were required to ensure that people received care that was safe and effective.

The management were respected by people, their relatives and staff.

The Old Vicarage Nursing 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 had made improvements since our previous inspection and was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and 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 27 September and was unannounced.

The inspection was undertaken by two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We looked at the action plan the provider had sent us following our last inspection. We looked at notifications the manager had sent us of significant incidents. Statutory notifications include information about important events which the provider is required to send us by law. We had discussions with the local authority to gain their views on the quality of service.

We spoke with eight people who used the service and five relatives. We spoke with the provider, operations manager, manager, five members of care staff, a nurse and the cook.

We looked at six people's care records, staff recruitment files, training and the systems the provider had in place to monitor the quality of service. We did this to make sure that the records were accurate and that the systems the provider had in place ensured a continuous improvement in the quality of care being delivered.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection we had no concerns in relation to people being safeguarded from abuse or the risk of abuse. At this inspection we found that not all unexplained injuries such as bruises had been investigated or reported to the local safeguarding authority for further investigation to rule out potential abuse. We saw one person's daily records and they stated that on two occasions the care staff had found unexplained bruising. This had not been reported to the manager or acted upon by the nurses. We saw that the care records for one person recorded that they made allegations about care staff abusing them on a regular basis. We saw that on some occasions the operations manager had discussed and looked into the allegations with the person and other occasions had not. The operations manager told us that the person had previously made false accusations but we could not see how the risk to this person had been minimised in the event of them telling the truth and having experienced an incident of abuse. This meant that the provider was not doing everything they could to protect people from abuse and improper treatment.

This was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection we had found that the provider was in breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people were not always receiving care that was safe. At this inspection we found that improvements had been made and they were no longer in breach of this Regulation. We saw that one person whom often became anxious and aggressive during personal care had received support from a health professional and staff had been shown a new way of supporting the person at these times. Staff we spoke with told us that they liked the new approach and found that it helped to keep the person calm and relaxed during personal care.

Previously we found that staff did not always respond in a timely manner when people used their call bells or their assisted technology such as sensor mat's set off the alarm. At this inspection we observed that staff and the nurses responded in a timely manner when people required support. One person told us: "The buzzer is by my bed, I ring it occasionally and the care staff always come". A relative told us: "A buzzer is by my relative's bed, which is a change that's been made as previously the buzzer was on the wall, out of reach, now it's always by them".

A relative told us: "I feel my relative and their things are safe here. My [relative] is sitting on a sensor mat on their chair which sounds an alarm if they try to get up. I have heard the alarm when I've been here and staff come and see if their ok". We found that risks to people were minimised following incidents that had caused harm or had the potential to cause harm. For example, one person had left the service and found that they had not been able to return as the equipment they used to mobilise had failed. The operations manager told us how they had minimised the risk of this occurring again by making sure the equipment was safe for use. However we found that this person's and other people's risk assessments were not always up dated to reflect the change and precautions put in place. This meant that not everyone may know the new identified risk and act accordingly to minimise it.

People's medicines were stored and administered safely. We saw medicines were stored in a locked clinical room and administered by the trained nurses. We observed medicines being administered and saw the nurse supported people to have their medicines in a way they preferred to take them. However we saw one person was using an as required (PRN) medicine on a regular, almost daily basis. We discussed this with the manager and operations manager who told us that this person and their medication was reviewed regularly with the person's GP but we found there was no record of any review.

There were sufficient staff to meet the needs of people who used the service. We observed that people did not have to wait for long to have their needs met. The manager showed us that they had a dependency tool which showed them the amount of staffing hours which were needed to meet the current people's needs. We discussed that consideration to the staffing levels would need to be made when new admissions into the service were permitted, The manager told us that they were currently recruiting so would be over the allocated hours and would keep it under constant review. We saw that staff were recruited using safe recruitment procedures by carrying out checks to ensure that new prospective staff were of good character and fit to work. These checks included disclosure and barring service (DBS) checks for staff. DBS checks are made against the police national computer to see if there are any convictions, cautions, warnings or reprimands listed for the applicant. However we discussed with the operations manager the need to ensure that staff currently recruited were monitored and risk assessed when there had been a change in their circumstances which may mean their character was in question.

Requires Improvement

Is the service effective?

Our findings

At our previous two inspections we found that the provider was not following the principles of the Mental Capacity Act 2005 (MCA) and were in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection the provider was still not following the principles of the MCA 2005. 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 found that several people who lacked mental capacity had still not been supported by a representative in the decision about a Do Not Attempt Resuscitation (DNAR) order being put in place. For example, one person's GP had stated the person did not have capacity to decide they wanted a DNAR but had put one in place without any representation of the person. This person had no family or legal representation and the staff had not gained any advice or support for the person. Staff at the service had completed an 'end of life' care plan and recorded that the person had agreed with the GP that the order should be put in place, however the GP's judgment was that the person did not have capacity to be involved in the decision making process. This meant that the provider was still not following the principles of the MCA and ensuring that people who lacked mental capacity are supported to make decisions about their care, treatment and support.

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

We found that continuing improvements had been made in relation to the applications to deprive people of their liberty. 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 are called the Deprivation of Liberty Safeguards (DoLS). Since our last inspection there had been several referrals for people who lacked capacity to the DoLS team. This was to ensure that any restrictions to a person's liberty was the least restrictive and in their best interest.

At our previous inspection we had found that one person was being deprived of their right to a cigarette when they wanted one. We had been told that this was in their best interest and they had the capacity and had agreed to the plan. We had seen that they had asked for a cigarette at a time contrary to the plan and it had been refused. This meant that the person's right to change their mind was not being respected. At this inspection we found that the care plan had been amended to reflect the person's right to change their mind and have a cigarette whenever they wanted one.

At our previous inspection we had concerns that people's nutritional needs were not always met and found the provider in breach of Regulation 14 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found no concerns and saw that when people had lost weight this was reported to their GP for advice. Several people were prescribed food supplements and we saw they had them at the times they needed them. The cook told us how they fortified food for people who were at risk of

malnutrition to add calories and maximise flavour. Referrals to the speech and language therapist (SALT) were made if people were experiencing difficulty in swallowing and we saw several people were offered a soft diet as instructed by the SALT. People had mixed views on the food, some people told us they enjoyed it and others told us they didn't. We saw that people who ate a normal diet had a choice of meals, however those on a soft or pureed diet had less choice. We discussed this with the cook who told us they would look into this and ensure more choice was available for all people who used the service.

We found that people's health care needs were met when they became unwell or their health care needs changed. We saw people had access to their GP, consultants, SALT and other health care professionals. We saw that the staff followed the advice of health care professionals to ensure people's needs were met, for example one person had been advised by the community nurse to use a piece of equipment for when they became anxious. Staff told us how they encouraged the person to use the equipment at the times they needed it. One person who used the service told us: "I don't take any tablets but if I feel unwell the staff will call the doctor". A relative told us: "There is access to the GP, recently an optician visited and now my relative has glasses, a chiropodist also visits".

Staff we spoke with told us that they liked and respected the new manager. They told us they were receiving regular support and had begun to have meetings with the manager to discuss their performance. Training was on going and regularly refreshed by an in house training manager. One staff member told us they were attending training to be able to train other staff in the safe moving and handling of people. This meant that people were being cared for by staff who were supported and trained to fulfil their roles.

Good

Is the service responsive?

Our findings

At our previous inspection we found that people were not always receiving care that met their individual needs. The provider had been in breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that improvements had been made and the service was responsive to people's individual needs. We saw people were offered choices by staff who knew them and their individual preferences. One person told us: "I couldn't find anywhere better than here. I feel safe here because the staff know me and I know them". Another person told us: "The staff asked me if I minded male carers, I told them I didn't, all the staff are nice".

We found that when a person had a change in their plan of care, for example when a person was prescribed antibiotics for an infection, an 'acute' care plan was put in place to ensure nursing staff knew the person's current care needs. We saw that staff treated people individually and offered them choices, we observed a nurse administering medication say to one person: "This is your pain killer, how would you like to take it with some water or squash?" This showed that the staff were responding to people's individual needs and preferences.

People were encouraged to be involved in hobbies and activities of their choice. We saw there was a planned activity schedule for people to join in if they wanted to. On the day of the inspection there was coffee morning and a chat. We observed the activity coordinator chatting with people, gaining their views on the food and planned activities. During the afternoon there was planned shoe sale which unfortunately got cancelled by the shoe firm. The activity coordinator set up an old time movie afternoon instead. A relative told us: "Recently there was a "day by the seaside" themed day. An ice cream van came and later, fish and chips were served. Another themed day for the Queen's birthday was a 1940s day. Staff, some residents and the singers were dressed up. The residents loved singing the old songs." We saw one person who was living with dementia and of a different culture had a film playing in their bedroom which was in their native language. This showed that people's individual cultural needs were being responded to and respected.

People and their relatives told us they were involved in their care and the running of the service. A relative told us: "The family attended a meeting to discuss the refurbishment plans; I felt I could speak up, and I received the minutes from the meeting. They ring me with any information about my relative. Recently my relative celebrated their birthday; they made them a cake, and gave them a present and a birthday card. I've never had to make a complaint and I've not seen anything to give me any concerns. I'm always made welcome and can visit anytime". Another relative told us: "I attend every meeting, usually held every 6 months. Some residents attend and some families. It's held in an evening and a beautiful buffet is laid on afterwards. I receive an invite to the meeting by email and get written minutes after the meeting. I give them 10 out of 10 for communication.

People and their relatives told us they knew how and who to make a complaint to if they had one. One person told us: "If I was worried I could talk to any of the staff. I think it's marvellous here". A relative told us: "I've never had any complaints here but I know what to do if I have one". The provider had a complaints procedure and we saw the complaints that they had received had been acted upon and concluded

satisfactorily.

Requires Improvement

Is the service well-led?

Our findings

Since our last inspection the previous manager had left and a new manager had been employed, who had been in post for three months and were in the processing of registering with us. Following the last inspection the operations manager had sent us a weekly action plan telling us that all the required improvements had been made. However at this inspection we found that further improvements needed to be made and the provider was still in breach of three Regulations of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Several audits were completed on a regular basis, including care plan audits. However when action needed was identified this was not always completed in a timely manner. For example we saw care plan audits which had identified that a DNAR order needed reviewing and this had not been completed.

We found that people were still not being supported to consent to their care in relation to the decision around a DNAR order. There was no system to ensure that the DNAR's in place had been discussed and agreed with the person or their representative and they remained active on people's care files. No one had been allocated the task of ensuring the DNAR's had been completed in line with the MCA 2005. The operations manager and manager were unable to tell us why the DNAR's had not been reviewed to ensure they had been completed correctly. This was the provider's third breach of this Regulation.

We saw that when unexplained injuries occurred this was not fed back to the manager to ensure they were appropriately investigated. Staff and the nurses recorded the injuries but did not pass the information on. The manager was unaware that there had been any recorded incidents of unexplained injuries as people's daily records were not audited regularly for the injuries to be noted and acted upon. This meant that people were at risk of harm from potential abuse.

Records and risk assessments were not always completed following a change in person's need or a heightened risk following an incident which could or did cause harm. Although the operations manager told us that action had been taken this was not always recorded to ensure that staff knew and followed people's risk assessments to provide safe, quality care. For example, we were informed that one person's use of PRN medicine was regularly reviewed by their GP but there was no record of this.

These issues constituted a continued breach of Regulation 17 of The Health and Social Care Act 2008.

People, relatives and staff spoke highly of the manager and operations manager and a relative told us: "The manager is relatively new. The operations manager is a very nice bloke. I was so impressed when I met him; he put an apron on and assisted with lunch. He knew the names of every resident". A member of staff told us: "I like the new manager she is a hands on manager and I think she's going to be good". Staff we spoke with told us that they felt the service had improved and that they had been supported by the management to make the changes that were needed to improve.

The provider told us they planned to continue with the refurbishment of the home and to support the new

manager to continue to improve and sustain consistent management as there had been several managers over a relatively short amount of time

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 11 HSCA RA Regulations 2014 Need for consent People were not always consenting to their care, treatment and support.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People who used the service were not always protected from abuse or the risk of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems the provider had in place to monitor the quality of the service were not always effective.