Future Health And Social Care Association C.I.C.

The Vicarage

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?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

About the service: The Vicarage is a respite service offering accommodation and support for people with mental health support needs. Three people were supported at the time of the inspection.

People's experience of using this service:
Overall people gave positive feedback about the service. People felt safe at the service. People carried on with their usual routines and their choices were promoted. There was not always an appropriate balance however between people's independence and safety. One person did not always feel they had the privacy they needed. Action was not taken to keep another person safe when their needs could not be safely met. We identified a breach of the regulations because people's medicines were not managed safely.
Staff told us they felt supported. Lone-working had been phased out, and improvements had been made to the premises to improve the safety of the service. Further improvements were planned, including to the premises, staff training and how incidents were logged. We identified a second breach of the regulations because systems and processes failed to effectively assess, monitor and improve the service.

More information is in the full report.
Rating at last inspection: Good (October 2017)
Why we inspected: This inspection was planned based on the previous inspection rating and was brought forward due to concerns known to CQC about the provider's other registered services.

Enforcement / Follow up: We identified two breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 around safe care and treatment and governance. During our inspection, we prompted the provider to address our safety concerns.

We also shared our concerns with the commissioning team that arranges referrals to the service.

We did not take enforcement action on this occasion because shortly after our inspection, the provider submitted an application to de-register. We will continue to monitor this provider and service until the de-registration process is complete.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our Well-Led findings below.

The Vicarage

Detailed findings

Background to this inspection

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

The inspection was prompted in part by wider concerns about the provider and risk management across their registered respite services. The information shared with CQC indicated potential concerns about the management of ligature risks. This inspection examined those risks and the safety of the premises.

Inspection team:
This inspection was carried out by an Inspector and an Assistant Inspector.

Service and service type:
The Vicarage is a registered care home without nursing. The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

What we did:
Before the inspection, we reviewed information we had received about the service since the last inspection. This included any notifications we had received from the service and feedback we requested from external agencies including the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We also spoke with commissioners and relevant teams for updates on their monitoring and oversight of this service.

Providers are required to send us key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We referred to this information to help plan our inspection.

During the inspection, we spoke with one person, a new support worker, and two support workers. We also spoke with two healthcare professionals, the service project lead and the registered manager. We also reviewed records related to three people's care and records related to medicines management, health and safety and quality assurance.

Some information we requested was not available to view during our inspection, including the training matrix, recruitment files, incident records and the provider's policies. We were told these records were stored at the provider's head office. When we visited the provider's head office the following day as part of our inspection activity, this information was not available. We confirmed our requests for information and received this information after the inspection.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm. Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. Some regulations were not met.

Assessing risk, safety monitoring and management;
Learning lessons when things go wrong

- The provider had recently carried out improvement works to remove and reduce ligature points to improve the safety of the service however further improvements were required.
- Staff told us they monitored some areas more closely such as the lounge, where some ligature points could not be removed. However, one person told us this was not done.
- Despite the provider's plans to increase staff awareness around ligature risks, relevant policies and guidance were not available for staff to refer to.
- Although risk assessments were completed to an improved standard, we were not assured all people's risks were thoroughly assessed. Two people's individual ligature risk assessments referred to the same incorrect name.
- The provider failed to identify and address that the person's needs were not being safely met despite numerous concerns about the person's self-neglect. The person's risks had not been adequately assessed, and staff did not have sufficient training or guidance to support this person safely.
- One person told us they felt safe but did not feel that their independence was also promoted on balance with their safety.
- Fire safety checks were regularly carried out as planned. Monitoring checks were carried out to promote people's safety and less often as and when people's health improved over time. Staff gave mixed responses as to how often they checked people's safety and we gave feedback that recorded guidance would help always ensure consistent and safe practice.

Systems and processes to safeguard people from the risk of abuse

- People confirmed they felt safe using the service.
- Staff had received safeguarding training.
- Staff knew how to identify and report abuse or allegations of abuse. However concerns about another person's self-neglect were not appropriately responded to.
- Records of previous incidents were not all available for staff or the registered manager to refer to and learn from. The provider was improving these processes to ensure all possible learning could be taken from incidents.

Using medicines safely

- People's medicines were not managed safely. One person's medicines were not all available and in response we were told, "That's pain relief so [healthcare professional] said not to worry about that." In relation to gaps in the person's medicines records we were told, "It's because [person] missed insulin I think." This demonstrated a casual approach and failure to ensure people's medicines were taken as

prescribed.
•□One person told us they 'sometimes' got their medicines on time, but they sometimes needed to prompt staff to always have their medicines on time.
•□Medicines records were not accurately maintained. Entries confirmed occasions where people missed their medicines or took medicines late. This had not been identified or effectively addressed with people's healthcare teams to ensure people's safety.
•□The provider did not ensure people's medicines were stored appropriately. There was no policy on site to inform safe medicines practice and storage.
•□Audits had not been carried out to help identify these issues.
•□Staff had either completed or were completing medicines training, and medicines competency assessments were not still carried out. We have previously informed the provider that current good practice guidelines recommend these to help ensure safe practice.
•□The provider had failed to ensure the proper and safe management of medicines. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulations 2014).

Staffing and recruitment
•□Staff no longer worked alone and they confirmed this helped improve the safety of the service. We recommend the provider develops a system to review staffing levels and deployment, to ensure staffing levels remain safe.
•□A new staff member told us they had completed recruitment checks before they started their induction.
•□The provider's recruitment checks included character references and checks through the Disclosure and Barring Service (DBS). This helped prevent the risk of people being supported by unsuitable staff.

Preventing and controlling infection
•□The service was kept clean by people and staff. Cleaning products were available for use and securely stored.
•□Staff had received training related to Infection Control and Health and Safety. Maintenance issues were reported and addressed.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence. The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law;
Staff working with other agencies to provide consistent, effective, timely care;
Supporting people to live healthier lives, access healthcare services and support;
Supporting people to eat and drink enough to maintain a balanced diet

- People made and prepared their own meals, and were supported with this if needed. A person told us they could cook when they wanted to.
- Staff knew people's individual circumstances, routines and general support needs. A person told us, "I like the support. I like having someone to talk to 24/7."
- Staff could not always demonstrate they had followed processes to contact healthcare professionals in relation to concerns about a person's health.

Staff support: induction, training, skills and experience

- People's records provided information to staff about people's risks and histories. However, staff had not been given all relevant training, or guidance about people's conditions and support needs to ensure staff had the skills and knowledge to support people effectively.
- Staff proactively sourced some guidance about one person's healthcare condition because the provider had offered no training or guidance. Our inspection found this person's healthcare needs were not effectively monitored and met.
- Staff had either completed or were completing additional relevant training related to mental health at the time of our inspection. Further training was underway, including the provider's mandatory training updates for some staff.
- Staff told us they felt supported and received regular training. Staff handovers were now documented to improve information sharing in the team.

Adapting service, design, decoration to meet people's needs

- The service had closed and reopened in January 2019 following redecoration. Welcoming signage and décor viewed at our last inspection had been removed through this work. One person told us more signage would help provide them with information they needed.
- The registered manager confirmed they would review this to redevelop the service's homely environment to welcome people and promote wellbeing.

Ensuring consent to care and treatment in line with law and guidance

- The Mental Capacity Act 2005 (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. People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. We checked whether the service was working within the principles of the MCA.

- People staying at the service could make their own decisions. We saw people came and went from the service as they wished. People's feedback had showed they felt involved in all decisions about their support.
- Staff had tried to encourage one person to make safer decisions about their health, however continued concerns had not prompted a review or consideration as to whether the person had full capacity. Staff had received MCA training.
- People had not been appropriately consulted about the use of closed-circuit television (CCTV) use at the service, brought in since our last inspection. A person told us CCTV use had not been discussed with them. The provider had not sourced or followed good practice guidelines in relation to this. No policy was available on site.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect. People did not always feel well-supported, cared for or treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care
•□People were encouraged to give feedback about the service, for example during house meetings. However people's feedback was not consistently acted on. One person's request to have a mirror for personal styling, although known to staff and the registered manager, was not recorded or acted on.
•□Another person approached staff with their concerns, which showed they felt comfortable speaking with staff and seeking their support. The person had completed a feedback survey about their time at the service and had stated they felt listened to and involved in their support reviews.

Ensuring people are well treated and supported; equality and diversity;
Respecting and promoting people's privacy, dignity and independence
•□One person told us, "The staff are really nice." Staff described ways they helped make people feel welcome and comfortable.
•□People could have visitors at the service, for example one person cooked a meal for their visitor.
•□Staff we spoke with showed consideration of people's privacy and independence. One person's feedback showed this had been their experience.
•□However, one person told us their privacy was not always respected. They commented, "Sometimes feel like a child, the way they talk to you. I know they have to make sure you're safe." We shared the person's feedback with the registered manager for further review.
•□Only one staff member had received recent training on equality and diversity. There was no guidance or policy on site for staff to refer to, to help ensure people's individual needs and preferences would be understood and met at all times.
•□One person expressed a preference to be referred to as a different gender. Our sample of records and discussions with staff found this was not consistently recognised.
•□Staff told us they helped signpost people if people wanted to attend religious services.
•□This was a mixed gender respite and arrangements were made to ensure people had their own privacy and space including separate sleeping areas and bathroom facilities, and additional lounge and kitchen areas.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs. People's needs were not always met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- Two people's wellbeing had improved over their time at the service. One person's support reviews showed their confidence had improved and they were developing new goals. Another person told us they felt healthier through their stay at the service.
- A staff member confirmed, "A lot of people will express what they need, a lot of it comes out in [reviews] and how we can encourage them, doing better in their own lives."
- However the referrals processes had failed to identify and address that a third person was admitted to the service without all necessary equipment and support to keep them safe. Staff had recorded, 'We don't know what to do' in the person's records in response to concerns about the person's health. This person's needs had not been appropriately assessed and met during their stay.
- People were encouraged to carry on with their normal routines. A healthcare professional told us, "What they do really well for people is talk to them, encourage them to do activities, assess things further such as social needs." A person we spoke with confirmed they had been supported with accommodation arrangements.
- Staff told us they encouraged activities depending on people's interests. One person had suggested having DVD nights and this had been done. However, the person commented, "It's kind of limited on what you can do, it can get boring."
- Other activities to promote wellbeing such as mindfulness were not promoted.

Improving care quality in response to complaints or concerns

- The registered manager told us the service had received no complaints.
- One person told us they knew how to complain, but would not feel comfortable doing so because the staff group knew one another. The person had not been given information such as about advocacy services to help seek independent advice.
- People were asked for feedback and reminded about the complaints process during house meetings.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture. Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations were not met.

Systems and processes to assess, monitor and improve the quality and safety of the service;
Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility;
Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements;
Continuous learning and improving care;

- Improvements to the safety of the service were not robust. Although new guidance had been developed about ligature risks, this was not made available for staff to refer to.
- Systems failed to ensure people's risks were effectively assessed and identified. Despite the provider's plans to improve their referrals processes, a person was admitted to the service although their needs could not be safely met. This was not reviewed despite continued concerns about the person's safety throughout their stay.
- Audits were not carried out as planned to oversee the quality and safety of the service.
- Policies were not available for staff to refer to for relevant issues at the time of the inspection in relation to CCTV, drug and alcohol use and medicines management.
- Incidents were not consistently logged and investigated to help improve the quality and safety of the service. The provider had plans to improve their systems.
- Leadership did not always demonstrate awareness of how to safely manage people's risks. The registered manager told us their recent audits had found no concerns with risk assessments and medicines management. Our inspection found improvements were required in both areas.
- The provider failed to operate effective systems to assess, monitor and improve the quality and safety of the service. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulations 2014).
- We were notified of incidents as required.
- The provider's last inspection ratings were displayed at the service and online as required.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;
Working in partnership with others

- Staff offered signposting support when people requested it. However systems did not ensure people's needs and preferences in relation to protected characteristics would always be gathered and met as far as possible.
- People were invited to attend reviews and house meetings. However people's feedback was not always used to develop the service.
- The provider had not followed good practice guidelines to fully consult people on CCTV use.

• Staff told us they felt supported. Healthcare professionals spoke positively about how staff communicated concerns to them. One professional told us, "They give us the information we want, that's good, we work together, any concerns they phone us."

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 provider had failed to ensure the proper and safe management of medicines. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulations 2014).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to operate effective systems to assess, monitor and improve the quality and safety of the service. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulations 2014).