Four Seasons (Bamford) Limited

The Old 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

This inspection took place on 27 November and 5 December 2017; the first day was unannounced.

At our previous inspection in July 2016; the service was rated as 'Good' overall. At this inspection the service was rated 'Requires Improvement' overall. This is the first time the service has been rated 'Requires Improvement'.

The Old Vicarage is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The Old Vicarage accommodates up to 30 people in one adapted building. At the time of our inspection 27 people lived at The Old Vicarage; one of these people had been admitted to hospital.

The service is required to have a registered manager. 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. At the time of our inspection there was a registered manager in post who was present during our inspection.

Evidence that actions had been taken to help reduce and manage known risks to people's health was not always available. Actions to reduce known risks in the environment and to help prevent and control infection were not always followed. Not all accidents and incidents were reported in line with the registered manager's expectations. Systems had not always been followed to ensure safeguarding referrals were made when allegations of abuse had been made. Systems and processes designed to assess, monitor and mitigate risks were not always followed. Required improvements had been identified as needed, however the required actions had not always been implemented.

Changes in people's levels of care needs had not always been referred to other organisations in a timely manner. Advice from other healthcare services had not always been clearly reflected in care plans and risk assessments. Not all staff were mindful of people's privacy and showed them sufficient consideration.

Records were not always accurate, complete or made contemporaneously. Records did not always demonstrate people received personalised and responsive care in line with their care plan. Sufficient numbers of staff were available, however we did not receive assurances suitable numbers of staff had been trained to competently use the fire evacuation equipment in the home.

People's communication and information needs were assessed; however one member of staff had not received the information and communication support they required.

People told us they felt safe and had not experienced discrimination. Procedures were in place to prevent

discrimination and the principles of the MCA were followed; information was accessible to people. Adaptions to the premises ensured it was suitable for people.

Medicines were managed safely. People received sufficient to eat and drink.

Staff were supported to develop skills and knowledge through training. Most people told us staff were kind and care staff spoke respectfully about people. People's independence and dignity was respected. People and families were involved in decisions about their care. People and families contributed to care plans. Processes were in place to provide support and care for people who were approaching the end of their lives.

The provider had clear values and aimed to provide good quality care where people could provide feedback. A registered manager was in place, and people found the registered manager approachable. Supervision processes were in place to support staff and the provider operated other systems to ensure staff were rewarded and valued.

At this inspection we found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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 safe.

Systems had not always been followed to ensure safeguarding referrals were made following allegations of abuse. Actions to help reduce and manage known risks to people's health were not always in place. People were not protected by the prevention and control of infection.

People told us they felt safe and had not experienced discrimination. Medicines were managed safely. Sufficient numbers of staff were available, however suitable numbers of staff had not been trained to use fire evacuation equipment in the home.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Changes in people's care needs had not always been referred to organisations in a timely manner. Advice from other healthcare services had not always been clearly reflected in care plans and risk assessments.

Staff were supported to develop skills and knowledge through training. Procedures were in place to prevent discrimination and the principles of the MCA were followed. Adaptions to the premises ensured it was suitable for people. People received sufficient to eat and drink.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Most people told us staff were kind and care staff spoke respectfully about people. However not all staff were mindful of people's privacy and showed them sufficient consideration.

People's independence and dignity was respected. People and families were involved in decisions about their care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Appropriate actions had not always been taken when people's care needs had changed. Records did not always support that people received personalised and responsive care in line with their care plan.

People's communication and information needs were assessed; however some staff had not received the information and communications support they required. People and families contributed to care plans. Processes were in place to provide support for people who were approaching the end of their lives.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Records were not always accurate, complete or made at the time care was provided. Systems and processes to manage the quality and safety of the service and to reduce risks were not always followed. Actions to secure improvements had not always been implemented.

The provider had clear values and aimed to provide good quality care where people could provide feedback. A registered manager was in place.

The Old Vicarage

Detailed findings

Background to this inspection

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

This inspection took place on 12 and 13 December 2017; the first day was unannounced.

The inspection team included one inspector, a specialist professional advisor who was a nurse 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. Their area of expertise was in the care of older people.

Before the inspection we looked at all of the key information we held about the service, this included whether any statutory notifications had been submitted. Notifications are changes, events or incidents that providers must tell us about.

This inspection was prompted in part by a pattern of notifications concerning pressure area care, serious injury and allegations of abuse. Information of concern had also been reported to the Commission prior to our inspection. Relevant incidents had been brought to the attention of the local authority safeguarding team. The information we held about the service before our inspection indicated serious impacts on people using the service and potential concerns about the management of risk in the service. Where an incident could be subject to criminal investigation, the circumstances of that specific incident were not investigated as part of this inspection. We did however look at the associated risks. These included management of risks associated with people's care needs, including continence care, pressure area care, falls and medicines; staffing levels and whether staff cared for people and spoke about people with respect and promoted their dignity.

As this was a responsive inspection we did not ask the provider to complete a Provider Information Return prior to our inspection. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

In addition, during our inspection we spoke with seven people who used the service and four relatives. We also spoke with the interim managing director, the registered manager, two representatives from the provider's resident experience team, a member of the provider's quality monitoring team and a pharmacy technician. In addition we spoke with three senior carers, two carers, the activities coordinator, the housekeeper and the cook.

We looked at the relevant parts of five people's care plans and reviewed other records relating to the care people received and how the care home was managed. This included risk assessments, quality assurance checks, staff training and recruitment records.

Requires Improvement

Is the service safe?

Our findings

People told us they felt well cared for. One person told us, "I think I have landed on my feet here. They look after me well." Care plans and risk assessments were in place for such areas as falls prevention and other areas of risk, such pressure area damage. Risk assessments were in place for any equipment people had been assessed as required, for example the use of a wheelchair or other mobility aid. Risks to people were assessed. However, care plans and risk assessments had recently been re-written and staff were still familiarising themselves with them. As a result staff were not fully confident about what was contained in people's care plans and where to locate guidance on specific aspects of people's care. One staff member told us, "I've not read a care plan since they've been re-written." There was a risk that care plans and risk assessments may not be fully effective as staff were not fully familiar with them.

Prior to our inspection we had been notified of a number of occasions where people had developed pressure area damage and other injuries. As a result of the local authority safeguarding and local clinical commissioning team involvement, people's care had been reviewed prior to our inspection. The provider had also conducted analysis of these occurrences and had made changes. The resident experience manager told us some of these changes had included, reviews of when people at risk of developing pressure damage were helped to change position, hourly checks on communal areas and the introduction of hourly checks for some other people. We looked at a sample of these records and found they were not always accurate, complete or completed contemporaneously. As records of people's care, and the actions taken to reduce risks to their health were not always accurate, complete or contemporaneous the provider was not able to provide full assurances these risks were being safely managed.

The registered manager had notified us since our last inspection of two separate occasions when the service had closed due to an outbreak of diarrhoea and vomiting. At this inspection, people told us they were satisfied their home and clothes were kept clean. We inspected the laundry and found a trolley for clean clothes had been placed next to the trolley for soiled clothes. The registered manager told us the clean trolley should have been stored in another area of the laundry so as to separate out clean and dirty clothes and to help prevent and control infection. This system had not been followed and this meant not all steps to help prevent and control infections were being taken.

We identified a lack of gloves and aprons in communal bathrooms for staff to use when providing personal care; there were also no clinical waste bins in two bathrooms. Staff told us they went to the administration office or an outside storage area to obtain supplies of gloves and aprons. The registered manager told us they would expect supplies of gloves and aprons to remain stocked up in communal bathrooms to ensure staff could access these items efficiently; they told us they would now ensure they were replenished daily. In addition they ordered new clinical waste bins so any clinical waste could be disposed of at source. Disposing of clinical waste at source helps to prevent and control the spread of infections. We also looked in the kitchen; we found areas of the kitchen required cleaning, including the fridge where shelves were dusty and overcrowded. We discussed our observations with the registered manager who told us they audited the kitchen on a monthly basis and they would complete an audit in response to our feedback. Shortly after our inspection the registered manager sent us a copy of their kitchen audit findings and action plan. This

established actions had been identified for where the required standards for food hygiene had not been met. Actions identified by the registered manager included a deep clean of the kitchen and dried food storage area, cleaning the fridge, food to be stored off the floor, fridge temperatures to be recorded correctly, staff training, food to be wrapped, labelled and stored correctly. The audit found some food was out of date and some had no use by date recorded; these foods were disposed of. Procedures to ensure people were protected by the prevention and control of infections had not always been followed.

Staff told us they would report any accidents and incidents, and most, but not all staff told us they would report a near miss. A near miss is an event that has not caused harm, but has the potential to cause injury or ill health; as such reports of near misses are important as they allow actions to be taken to prevent and reduce risks. During our inspection we observed staff attend to a person as they showed signs of injury. We discussed this with the registered manager who confirmed they would expect the incident to be reported on the accident and incident reporting system; however this had not happened. The registered manager provided records to show the incident had been recorded in the person's daily records. This confirmed staff had observed blood and had cleaned the area and found no marks or scratches and so it was unknown where the blood had come from.
Reports of accidents and incidents were reviewed for any trends and to check all actions to reduce risks were being taken. However, as this incident had not been reported in line with the registered manager's expectations, we were not assured all steps had been taken to identify actions to improve safety. In addition, we were not assured all steps had been taken to help identify when things went wrong and to identify learning to implement further improvements.

Risk assessments were in place for the general environment and management of the service; however these had not always been complied with. For example, we found one risk assessment stated a person's thickening powder should not be left in view, due to the risk towards some people living with dementia who may ingest the powder. However during our inspection this person's thickening powder had not been stored in line with the risk assessment, and had been left out in their bedroom. We also found sachets of gel containing a local anaesthetic and antiseptic and sachets of adhesive plaster remover used by other visiting health professionals left in one person's room. During the first day of our inspection, a fire door had, on multiple occasions, not been kept closed as instructed on the fire door notice; we made the registered manager aware of our concerns. We also reported to the registered manager that the fire door appeared to require some maintenance to enable it to close properly. On the second day of inspection the registered manager told us maintenance work had been completed to ensure the door closed easier and staff had been reminded to keep it shut. However, despite these actions having been taken, we still found the fire door left open on multiple occasions on the second day of our inspection. Actions to reduce known and identified risks were not always consistently taken.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found a letter of complaint had been received and contained allegations of abuse. Whilst these had been investigated and responded to as a complaint by the service, no statutory notification for an allegation of abuse had been submitted to the CQC as required. The registered manager told us they were not aware that a safeguarding referral had been made for the allegations of abuse; they later told us the safeguarding team had been aware of the allegations. When we checked with the local authority safeguarding team, they confirmed they were aware of one of the allegations of abuse, but not all of them. This meant the lead agency for the coordination of any investigation into allegations of abuse had not been fully informed. We asked the registered manager to make a safeguarding referral for all the allegations of abuse and submit a statutory notification to the CQC. Ten days later we had still not received the statutory notification to

confirm the safeguarding referral had been made; we made the safeguarding referral direct to the local authority. The registered manager told us there had been a delay as she was locating the original paperwork before making the safeguarding referral as requested. We were not assured the correct procedures for reporting allegations of abuse had been followed. People's safety was not always supported as safeguarding referrals had not always been made as required.

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

Other maintenance type checks on the premises and equipment were in place to provide assurances services were safe, for example checks were completed on equipment and slings used to help people mobilise.

People told us they had not experienced any discrimination whilst at The Old Vicarage and told us they were happy with how staff cared for them. People also told us they felt safe; for example, one person told us, "I know I am safe here because I can get help any time and people can only get in or out of here with passwords." Relatives we spoke with shared the view their family members were safe. One relative told us, "It's comforting to know that [family member] is not at risk any longer – there is always someone there to check on them."

People who received care from staff to help them mobilise told us they felt safe when staff assisted with this. For example one person said, "I am happy with being hoisted as the staff take their time and explain it to me." Another person said, "I have to have help moving about in my room sometimes, but the [staff] are good. Some days I can do more on my own."

People we spoke with told us that on the whole, staffing levels were good; people who used a nurse call bell to request help told us staff came to help them within a reasonable time. One person told us, "They come pretty quickly when you call, depending on how busy they are." Another person added, "There is usually someone floating about that can help you." A third person told us, "I think there are enough staff here to get the job done, but then I am pretty independent." However one person commented on night time staffing levels; they said, "I think they are a bit short of staff on the night shift." Prior to our inspection we saw concerns were raised with the registered manager over staff break time impacting on staff being available to care for people. At this inspection we saw the registered manager had taken recent action to ensure staff took their breaks in an organised way so to minimise any impact of people's care.

The registered manager told us people's needs were individually assessed and these informed the levels of staff required. However, the registered manager told us assessments of people's needs had, up until recently, not always established people's needs accurately. People's needs had now been reassessed and were found to be higher than previously assessed. As a result the registered manager now had additional staff deployed to meet people's needs. Staff told us they were able to give better care now they had additional staff. One staff member told us, "We had periods of being a bit short about a month ago; we [staff] were more stressed and the service users feel it." Another member of staff told us, "We [staff] didn't feel we had enough time; there was no time to talk to people and we were just doing things quickly; now there is. It had been understaffed as people had higher level needs. [Having more staff] It's made a massive difference; staff were crawling out of the door, now we have more staff we can meet people's needs." We observed staff were deployed in a way which meant main communal areas had a staff presence. Prior to our inspection the provider had identified staffing levels had not been calculated so as to always meet people's needs.

However we asked the registered manager for assurances that there were enough staff on each shift to

competently use the fire evacuation equipment used in the home. The registered manager did not provide these assurances. Although the provider had taken action to improve staffing levels and at our inspection; and there were sufficient staff deployed to meet people's needs; the registered manager did not provide assurances that enough staff were competent to use the fire evacuation equipment in an emergency on each shift.

People told us staff helped them with their medicines and they received their medicines regularly. One person told us, "[Staff] come with my pills morning, noon and night. They are in a little pot and [staff] stand and watch me take them." Another person told us, "I get my medication regularly. I can't remember what they are all for, but I have faith in [the staff]." One person told us staff did not always tell the person what their medicines were for when they asked. They said, "I do ask [staff] what all my pills are for sometimes, but they don't seem to know." People also told us they received pain relief when they needed it. They said, "I am having more painkillers at the moment because [I am in more pain because of the weather]. I just have to ask, but I don't want to take too many." Guidelines were in place for any medicines administered when required so that people received pain relief when needed.

We saw staff administer medicines to people and observe them to ensure medicines had been taken. Medicines administration record (MAR) charts were completed after any administration. The provider had policies and procedures in place for the management and administration of medicines. In addition, regular medicines audits were completed; this included audits and checks completed by the provider's own pharmacist technician, one of which had been completed during our inspection. These actions helped to ensure people received safe care around the management and administration of their medicines.

Some medicines were subject to additional storage and administration procedures; we saw these were in place and records for these medicines had been completed in line with good practice. We checked the amount of some medicines against those recorded as being in stock and found these were correct. However, we found three bottles of liquid medicine where the date of opening had not been recorded; this is important as some medicines require disposal after being open for a period of time due to a decrease in their efficiency.

Requires Improvement

Is the service effective?

Our findings

Prior to our inspection, as part of the local authority safeguarding investigation we were made aware some people's care had been reviewed and they were found to require nursing care. The Old Vicarage is a residential care home and is not registered to provide nursing care. The registered manager told us although they had recognised people's needs had increased they were not aware they could request a review of people's care needs from commissioners to establish the best arrangements to meet the person's changed care needs. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority or by a health clinical commissioning group. We were concerned changes in people's care needs had not instigated referrals to commissioners and other appropriate health professionals and that people's nursing needs had not been fully met.

Staff told us they worked with other organisations and other professionals involved in people's care. For example, they told us they would involve the local district nursing team if they had concerns any wounds were not healing as they should. Records showed other professionals had been involved in people's care when appropriate. For example we saw an assessment had been completed by a speech and language therapist (SALT) for a person who had swallowing difficulties. However the person's care plan did not clearly reflect the advice of the SALT assessment. We discussed this with the registered manager who agreed to liaise further with the SALT team and ensure the person's care plan clearly reflected the professional advice they had been given. People had not always received effective care because actions to ensure people with nursing care needs had not always been assessed when appropriate and advice from other professionals had not always been clearly reflected in people's care plans.

People told us that they felt staff had the appropriate training to carry out their roles. One person told us, "[Staff] know their stuff; they just get on with it." Another person told us, "I am happy with the staff." Staff told us they had regular training, although staff told us not everyone was trained in how to use the fire evacuation equipment. The Old Vicarage had recently completed the provider's accreditation scheme for dementia care. Staff told us the dementia training had been designed so they could appreciate and understand some of the sensory loss that can present when people are living with dementia. Records showed staff had received training in areas relevant to people's needs, such as health and safety, medicines and food safety. Records showed most staff had completed the training in line with the provider's expectations; the registered manager told us they regularly reminded staff to ensure their training was completed as required. Whilst staff had been provided with training to help them have the skills, knowledge and experience they needed to deliver effective care and support; the registered manager had not provided assurances all staff were trained and competent to use the fire evacuation equipment provided in the service.

Assessment of people's diverse needs, including in relation to protected characteristics under the Equality Act 2010 were considered to help ensure people did not experience any discrimination. Records showed for example, whether a person held any particular faith. Recruitment records showed staff were asked about their needs in relation to protected characteristics under the Equality Act. Procedures were in place to help prevent discrimination.

People told us they saw other healthcare professionals, for example, their GP or a chiropodist when needed. One person said, "I can see the GP if I want to, or sometimes they just check on me anyway." Another person told us, "I had the nurse come and check me all over for sores two weeks ago." Two people told us if they needed to travel to a health appointment, staff would accompany them if their family members were unavailable to do so. Staff we spoke with told us they were aware of the care people required. Records also showed people had received support with their healthcare from other healthcare professionals, such as speech and language therapists, GP's and dieticians. People were supported with their health as care staff knew how other healthcare services could benefit people.

People and families we spoke with told us staff asked permission to help provide care and respected their views if this was refused. People also told us they did not feel their freedom was restricted. One person told us, "I can move about safely between floors. I just use the lift to go downstairs and then out into the garden for a smoke. It's no bother." Staff we spoke with told us they only provided care to people with their consent.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Records showed DoLS authorisations had been applied for and the registered manager kept any expiry dates under review.

We checked whether the service was working within the principles of the MCA. The service had policies in place that covered the MCA and making decisions in a person's best interests. When people lacked the mental capacity to make some specific decisions by themselves these had been made in meetings with other professionals and family members when appropriate. These meetings were to discuss what decisions were considered to be in a person's best interests. The service had information available on how to make referrals to advocacy services if people required an advocate in any decision making meetings. People's consent to their care and treatment was sought by staff in line with the MCA.

Assessments of people's needs were completed in line with current legislation, for example decision making was taken in line with the MCA. Where people required specific assessments associated with their health conditions we saw referrals had been made so the assessment could be made by the appropriate professionals and in line with their professional standards. For example, we saw assessments included screening tools for malnutrition, skin integrity, continence and moving and handling. Assessment processes were in line with current legislation and standards that aim to achieve effective outcomes for people.

Most people told us they were satisfied with their meals and were offered choices. One person told us, "They ask me what I want for lunch and then they bring it to me [in my room]; I can't grumble at all about the food; I have never had a bad meal yet." Another person told us, "I enjoy the food. A bit too much maybe, as I put on some weight and had to ask for smaller portions." A third person said, "The food can be a bit up and down. Some days good, some days not so good. If I feel hungry I tell them and they make me a sandwich."

Staff we spoke with were knowledgeable about people's dietary requirements and how to meet these. The cook told us how adjustments were made for people who followed diabetic or modified texture diets. Records showed people were assessed for any risks regarding nutrition and dehydration and identified what further monitoring was required. Care plans contained details on people's dietary and fluid needs to ensure people had adequate nutrition and hydration. People received a balanced and nutritious diet.

People told us they could get around the building as needed. For example one person told us, "My [relative] is grateful for the lift [between floors] when they take me out." Adaptions had been made to the premises when needed. For example we saw the different floor levels were accessible by a lift so that the building was accessible to people without the need to use the stairs. A nurse call alarm system had been installed which meant people had a call bell they could use to when in their rooms to alert staff if they required care. People's individual needs were met through the adaption of their premises when needed.

Requires Improvement

Is the service caring?

Our findings

Prior to our inspection, we had received information of concern that some staff did not always care for people in ways that were caring, dignified and respectful. This information had also been raised with the provider. They had taken steps to investigate the concerns and to monitor the care provided to ensure it met with the provider's expectations.

During our inspection most people and their families told us they felt staff were kind. One person told us, "The staff couldn't be kinder. I have nothing but admiration for them." One relative said, "I can tell that [family member] is happy here because I can hear them whistling as I walk down the corridor. They only do that when they are happy." Another relative said, "Staff are kind; I've seen worse homes and I've seen better, but [my family member] seems content." However, one person told us, "I think they [staff] could be a bit nicer sometimes, but they are always busy and they get the job done." Another person told us when they had not been satisfied with the approach taken by one member of staff, they reported their concerns and the situation improved. They said, "I did complain about a [staff member] who spoke to me like a child. They talked to [them] about it because it hasn't happened since."

We saw care staff knocked on people's bedrooms doors and waited for an answer before entering. However, we saw one person was startled by a staff member who walked straight into their bedroom to complete a maintenance task. The person appeared uncomfortable as they had poor vision and did not know who had walked into their bedroom. Not all staff respected people's privacy and took steps to introduce themselves and explain their presence.

Staff we spoke with told us they were satisfied people were cared for and spoken about respectfully and if they had any reason to believe this was not the case they would raise their concerns with the registered manager. Where concerns had been raised with the registered manager we could see they had been investigated. We observed staff spoke with people respectfully on our inspection.

Two people told us they enjoyed chatting to care staff when there was time. One staff member told us how as a result of the recent increase in staffing, they were now able to spend more quality time with people. They said, "I feel we can do more; we can sit with people more now." They went on to tell us about some of the things the person enjoyed seeing and chatting about, and how they took things in to show them. We observed when people showed signs of being unsettled, staff reassured them and asked them how they were feeling and asked if they needed anything. Staff were aware of how people were feeling and were able to take the time to offer reassurance when needed. The provider had taken action and was continuing to monitor care to ensure staff treated people with care, respect and dignity.

People and their families told us care staff promoted their independence and dignity. One person told us, "They respect my dignity when they are giving me help." One relative told us their family was, "Involved in the gardening as [care staff] know they love to be out there." People also told us they felt care staff promoted their independence as they were given choices on a day to day basis. During our inspection we observed people independently pursued how they choose to spend their time. One person told us, "I get to

please myself." The provider had supported staff to register as 'dignity champions'. Dignity champions register with the national Dignity in Care Campaign. The national Dignity in Care Campaign works to ensure people have a good experience of care when they need it. People's dignity was respected and their independence was promoted.

People were given the opportunity to be involved in discussions about the care and support they required. One relative told us, "Yes we seem to have choices; we had an assessment before [family member] came in; I was involved in that with [another family member]." Records confirmed care plans were discussed with people and their views and preferences for care were recorded.

Requires Improvement

Is the service responsive?

Our findings

Prior to our inspection some people had been identified as requiring nursing care. We were not assured people who had been identified as having nursing needs had always received responsive care. This was because The Old Vicarage is not registered to provide nursing care and the registered manager told us she had not realised she could request a review of people's care to determine if they were now more suited to nursing care.

Some people required staff to offer care at specific and regular times and in line with their care plan to ensure they received the care identified as required. For one person, staff kept records of when this support was offered. However as we witnessed staff make retrospective records for this person's care, we were not assured this person had been offered the personalised and responsive care they required.

The Accessible Information Standard applies to people who have information or communication needs relating to a disability, impairment or sensory loss. It covers the needs of people who have a condition which affects their ability to communicate. Whilst the registered manager's knowledge of the Accessible Information Standard was limited, she told us, and records confirmed people's communication needs were assessed.

Where people had communication needs identified, staff were knowledgeable on how to communicate with people. For example, one staff member told us they made sure one person who had a hearing impairment could see their face when they spoke to aid communication.

However, one staff member told us they had not received assistance to help them with an information and communication need; they told us they believed their manager was aware of their additional need. The registered manager told us they were unaware of this need; it had however had an impact on the staff members role as they required additional assistance to be able to fulfil their role effectively. The registered manager confirmed actions to make communication improvements for some staff would now be taken.

One relative told us how they were involved with the assessment and care plan when their family member first moved to The Old Vicarage. They went on to tell us they had continued to be invited to regular family meetings to review their family member's care. They told us, "I feel able to approach them and staff always greet me with a 'hello, do you want a cup of tea?' when I arrive." They added, "[My family member] is clean, well fed, nails are clean, toe nails are cut and [family member] is always clean and tidy." Another relative told us they felt the care was responsive and personalised to their family member's needs. They said, "Since [family member's] Alzheimer's has got worse, it has affected their swallowing so staff now feed them a soft diet and they have to have thickener in drinks, but they seem content." Care plans showed evidence of discussion with people and their families and care plans had been regularly reviewed. People and their families contributed to care plans; this helped to support personalised care.

When appropriate, plans were in place for people to receive appropriate care at the end of their lives. Records showed any decisions on resuscitation were in place. These showed evidence of having been

discussed with people and their families and had been signed and dated by the person's GP.

People told us they spent their time as they wished and enjoyed the time they spent with staff. One relative told us, "[Family member] really enjoys the activities here and especially the dominoes, bowls and quizzes. [Staff] also encourage them to do some of the creative stuff and they really end up enjoying it. [Staff member] has been brilliant. It's strange that they don't seem to use the activities room any more though, I used to be able to join them in there but there isn't enough room in the lounge to do that which is disappointing." Another relative commented on how staff understood their family member and their life history. They told us, "[Care staff] know what [my family member] did for a living." They went on to say, "[Care staff] get on with everyone; they don't ignore people." One person commented that there seemed to be fewer trips out then previously. They said, "There used to be quite a lot of trips out, but these seem to have stopped since the last activities person left and I don't know the new one. I like puzzles and crosswords and sometimes the staff sit with me for a little while as I prefer to stay in my room but then they have to go." The activities coordinator told us it was sometimes difficult to get a driver for the minibus and as a result there had been a reduction in trips out and about. The activities coordinator told us they provided activities based on people's individual needs as well as organising group events. During our inspection we saw people taking part in activities provided by the activities coordinator. People were observed to be in good spirits, having fun and enjoying sharing conversation with one another. People also enjoyed a visit by a local school choir during our inspection. People had opportunities to join in activities and links to the local community were supported.

People told us they knew how to complain and give feedback. One person told us, "I don't complain a lot, but when do I speak to [name of staff member]; they know I want support." A family member told us, "They always resolve any issue." However another family member told us they had complained about lost personal items and although they felt staff had done their best to locate them, they were never found and they received no apology. Information on how to make a complaint was available for people. Records showed where people had made a complaint, these had been investigated and people informed of the outcome. The provider had a complaints policy in place and procedures for staff to follow when managing complaints. In addition, people could leave feedback on a computer in the main reception area. Reports of feedback left on this computer were sent directly to the registered manager and regional manager. This helped the provider to be able to respond quickly to any feedback given in this way.

Requires Improvement

Is the service well-led?

Our findings

Systems to ensure quality records and data management were not always effectively operated. Records of people's nutritional intake were in place and from our observations we found these had been made contemporaneously. However, records of how risks around people's pressure area care, continence care and general wellbeing were monitored were not always complete, accurate or made contemporaneously. For example, we asked to see records to show a person had been assisted to the toilet in line with their care plan. Staff were not able to locate these straight away and told us they had not yet been started for that day. Later, just before lunchtime staff told us they had the chart they needed to commence records for this person's continence care. We witnessed a staff member make a record stating the person had been assisted to the toilet at 10am. We asked the staff member what the provider's view was on making retrospective records of people's care. They told us they would have been assisted to the toilet soon after breakfast and normally the records would be available to complete at the time. The staff member did not demonstrate knowledge that people's care records were required to be accurate, factual and completed contemporaneously.

We looked at another person's care records. They required repositioning to reduce risks of pressure areas and required regular observation to check their general well-being as they were cared for in bed. We checked their records at 1pm and again at 2.30pm. We found one retrospective entry had been made to their position chart and another two retrospective entries had been made to their regular observation checks between these times. We looked at further care records for a selection of other people. One person required care to help change position every three hours to help prevent pressure areas. We found no records had been made for six hours during our inspection. Another two people required hourly checks to help ensure their safety. We found records of their checks had not been made for four and a half hours for one person and five hours for the other person. Staff also made records to show the communal lounge area was checked by staff each hour. No records for the upstairs communal lounge had been made for over three and a half hours for one afternoon of our inspection. We observed an incident on 12 December 2017 and the registered manager supplied the records made for the incident for our review. The records supplied were dated 13 December; there was nothing in the records to state the correct date of the incident. Records of people's care were not always accurate, completed contemporaneously or complete.

Meeting records showed the improvements required in record keeping had been discussed with staff in November 2017. They had also been discussed at a meeting with the local authority in November 2017. The provider's audit identified on 1 December 2017 there were still concerns with staff falsifying records and neglecting care needs. At our inspection on 12 and 13 December 2017 we found records were still not always accurate or made in a contemporaneous manner. When we spoke with the provider's senior staff members and they told us they thought record keeping had improved; we found this was not the case. Therefore the provider's assessment on the quality of some record keeping was not effective as at the time of our inspection the provider had not identified records were still not being made in a contemporaneous or accurate manner. Actions taken to improve record keeping had not been effective.

The provider completed audits to check on the quality and safety and the general running and management

of the service; these included an analysis of falls and incidents. However these systems and processes designed to assess, monitor, improve services and identify and mitigate risks were not always effective. This was because the registered manager told us they did a daily walk round to check the service was operating in line with the provider's expectations. However the registered manager had not identified that clinical waste bins and supplies of gloves and aprons were not in some communal bathrooms as expected. Nor had they identified clean laundry was not being stored separately from dirty laundry in the laundry area as expected. Nor had the registered manager identified a fire door was in need of repair and had been routinely left open, despite notices to say it should be kept shut. The registered manager also told us they were responsible for completing monthly audits on the kitchen area. During our inspection we observed some shortfalls in the cleanliness and organisation of the kitchen area and reported our finding to the registered manager. Records of a team meeting in November 2017 stated, 'Kitchen does require a deep clean and this is to be maintained; [staff] need to ensure all staff are adhering to the cleaning schedule.' An audit by the provider on 1 December 2017 had identified not all fridge and freezer temperatures had been recorded. This meant, despite shortfalls having been identified in November 2017 and at the start of December 2017, no improvements had been achieved at our inspection on 12 and 13 December 2017. After our feedback on the concerns regarding the kitchen, the registered manager completed an audit which confirmed shortfalls in the standards of cleanliness and operation of the kitchen. This meant when shortfalls were identified, effective actions were not always taken.

Although the provider operated a system to analyse accidents and incidents for any trends and improvements, not all accidents, incidents and near misses were reported on this system in line with the registered manager's expectations. This meant that analysis of accidents and incidents was not fully effective at improving services and mitigating risks as not all accidents and incidents were reported in this way.

The provider used a dependency tool that looked at the level of care needs to calculate the numbers of staff required to meet those needs. Prior to our inspection the provider identified this had not been used correctly; this resulted in people's care needs calculated as lower than they actually were. As a result, prior to our inspection, staffing levels had not always been sufficient to meet people's actual care needs. Although the provider had identified and rectified this prior to our inspection, we were concerned that people's care needs had not previously been met due to people's care needs being incorrectly assessed.

We were also concerned that the registered manager told us they had not realised they could refer people for a care assessment involving other health care professionals and commissioners when their care needs changed; specifically when their care needs showed signs of developing into requiring nursing care to meet those needs. Prior to our inspection a number of people had been assessed as requiring nursing care and therefore required care in another setting. This was because The Old Vicarage is only registered for residential care and cannot provide nursing care. Although the registered manager had not always worked effectively in partnership with other agencies and made referrals when needed, they had, along with the provider's other senior staff members engaged with partner agencies to work towards improvements.

The registered manager told us all staff had been trained in the use of fire evacuation equipment; this was in contrast to what staff told us. One staff member told us, "A certain few [staff] have been trained," another member of staff told us, "Two [staff] are trained to use that." We made a specific request to the registered manager for evidence to show all staff had been trained in the use of the fire evacuation equipment in the service. We received no evidence from the registered manager to provide assurances all staff had been trained in how to use the fire evacuation equipment as they had stated. The registered manager had not provided assurances that systems and processes to assess and mitigate risks to the health, safety and welfare of people were being effectively operated.

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

People told us they felt the senior staff and registered manager were approachable. People told us there had been meetings in the past where they could discuss the service. We also saw people had been asked their views on the quality of the service and these results and the actions the provider was taking to further improve people's experiences were on display in the main reception area. Thank you cards received from people and families were also on display. These contained positive comments about people's care, for example, one person had recently commented on the helpful and considerate care provided. A relative also told us they had found the provider helpful when they transferred their family member to live The Old Vicarage.

The Old Vicarage is required to have a registered manager and a registered manager was in post. 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. The registered manager understood when notifications were required and had submitted notifications for example, when a person had sustained a serious injury. Notifications are changes, events or incidents that providers must tell us about. However, we found allegations of abuse had been made in a letter of complaint and the registered manager, had at the time, not submitted a statutory notification as required. We requested the registered manager submit a statutory notification for the allegations of abuse and this was later submitted.

Prior to our inspection we spoke with the nominated individual for the provider. During our inspection we spoke with the interim managing director. Both the nominated individual and interim managing director were open and transparent about the concerns that had been shared with them, the issues that had identified and the steps they were taking in response. This had included reviews and revisions of care plans and risk assessments, monitoring and observing care to ensure it was respectful and caring, providing opportunities for people, families and staff to raise any concerns, actions to improve record keeping, identification of the correct amount of staff required and supplying those staff to meet people's needs and additional management and clinical support for the registered manager and service. The provider had an action plan in place to identify the areas of improvement needed. Whilst not all actions the provider had taken had been fully effective, for example improvement in records keeping and ensuring the kitchen was operating to standard; the provider did demonstrate a commitment to improve.

The service's aims were to provide quality care for people. For example, the provider had a 'quality of life programme' that set out how the provider intended to ensure people experienced quality care. The provider also aimed to provide quality dementia care and supported this through the training and development of staff. In addition, the provider had a charter for people and their families; these set out the provider's aims for people to receive personalised care. The provider had taken actions in response to information that raised concerns over people not receiving the care they required and not being treated with dignity and respect at all times. These actions included observations of staff communication, creating opportunities for families to meet with the provider and providing opportunities for staff to be able to make any disclosures under the Public Interest Disclosure Act 1998 (PIDA). PIDA is a law that protects staff from being treated unfairly by their employer if they have raised genuine concerns about a person's care. We were assured the provider was taking action to ensure people were treated with respect and dignity and people's independence and involvement was promoted by all staff.

Staff told us and records confirmed they received support in their role from supervision meetings.

Supervision provides staff members with the opportunity to reflect and learn from their practice, receive personal support and professional development. Records also showed meetings were held amongst the staff groups with the aim of sharing information on relevant areas. Staff told us they found the registered manager approachable and supportive. One staff member told us, "We have good carers and a good manager." The provider operated staff recognition schemes and information was available to staff on how to nominate staff for recognition. Staff felt supported in their role, had opportunities to contribute their views and to receive recognition.

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 Service users care and treatment was not always provided in a safe way as not all reasonable practicable action to mitigate risks were taken. Parts of the premises were not always used in a safe and as intended way. Not all actions to prevent, detect and control the spread of infections were taken. (12) (1) (2) (b) (d) (h)

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 Service users were not always protected from abuse and improper treatment as systems and processes were not always operated effectively to ensure allegations of abuse were reported to help prevent abuse of service users. 13 (1) (2)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes designed to assess, monitor and improve the quality and safety of services, in addition to assess, monitor and mitigate risks relating to the health, safety and welfare of service users and others were not always operated effectively. Accurate, complete and contemporaneous records in respect of the care and treatment provided to service users had not always been maintained. 17 (1) (2) (a) (b) (c)

The enforcement action we took:

We issued a warning notice to the provider and registered manager.