

Bakewell Vicarage Care Home 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

About the service

The Old Vicarage is a residential care home providing personal and nursing care for up to 24 people. The service provides support to older people, people with dementia and people with sensory impairment or physical disability. At the time of our inspection there were 23 people using the service.

The home is close to the centre of Bakewell and set in its own grounds. It is one building with a lounge, dining room, conservatory and garden. Twenty-two of the 23 bedrooms have en-suite facilities. Two of the bedrooms are shared accommodating 2 people.

People's experience of using this service and what we found

People were not always protected from avoidable harm. Actions recorded as taken following safeguarding incidents were found not to be in place and lessons were not learnt so incidents reoccurred. Known risks had not always been mitigated. For example, when a person had suffered a fall, we found no actions had been taken to investigate the cause or to review the person's needs. Risks identified in the service's fire safety risk assessment review from March 2022 had not been addressed.

The provider was not consistently working within the principles of the Mental Capacity Act (MCA). We found a locked door which restricted a person's access to their bedroom. People's needs had not always been thoroughly assessed prior to them joining the service. Managers did not ensure staff had regular supervisions.

People's dignity was not always promoted. Relatives told us about issues they had encountered with the laundry and how family members were often found wearing other people's clothes. We observed staff treating people well with care and kindness. However, we found the provider's systems and practices did not always support this as not all risks had been mitigated to ensure people were safe.

The provider had not actioned all improvements since our previous inspection. We found ongoing issues with safeguarding and governance systems. We found improvements were in place for supporting people to follow interests; an activities coordinator provided a range of activities. People had the opportunity to participate in activities in a group or on a one to one basis with staff.

The quality assurance and governance arrangements in place were not robust. Systems and processes were not effective in actioning findings from medicine and mealtime audits in a timely manner, so shortfalls identified continued to reoccur.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

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

Rating at last inspection

The last rating for this service was requires improvement (published 16 April 2020). The service remains rated requires improvement. This service has been rated requires improvement for the last four consecutive inspections.

Why we inspected

We carried out an unannounced comprehensive inspection of this service on 12 November 2019. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve. This inspection was carried out to follow up on action we told the provider to take from the last inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The overall rating for the service has remained requires improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Old Vicarage on our website at www.cqc.org.uk.

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safeguarding people from abuse and improper treatment, governance and management oversight at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement ●

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement ●

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

The Old Vicarage

Detailed findings

Background to this inspection

The 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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team

The inspection was carried out by 2 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.

Service and service type

The Old Vicarage is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. The Old Vicarage is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager

This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A new manager had been in post for two months and was in the process of submitting their application to register. We are awaiting this application and will assess this once received.

Notice of inspection

This inspection was unannounced.

What we did before inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection

We spoke with 3 people who used the service and 10 members of staff including the deputy manager, senior care assistant, domestic assistants, care assistants and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with 8 relatives about their experience of the care provided.

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. At this inspection the for this key question has remained requires improvement. This meant 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.

At our last inspection systems were not robust enough to demonstrate safeguarding was effectively managed. This placed people at risk of harm. This was a breach of regulation 13 (Safeguarding Service Users from Abuse and Improper Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider remained in breach of regulation 13.

Systems and processes to safeguard people from the risk of abuse; Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- People were not always protected from the risk of abuse.
- Safeguarding systems in place were not robust and lacked management oversight. When incidents occurred, we found lessons had not always been learnt and incidents reoccurred.
- People were not always protected from the risk of avoidable harm. We found that actions recorded as taken to mitigate risks following safeguarding incidents were not in place.
- Safeguarding incidents that had been recorded had not always been investigated appropriately by the manager or provider.
- Systems were in place to monitor and analyse safeguarding incidents, however this process had not identified when records were incomplete.
- Known risks had not always been mitigated. For example, when a person had suffered a fall, we found no action had been taken to investigate the cause or to reduce the risk of this happening again.
- The person's care plan had not been updated and stated their mobility needs were 'low risk'. The person did not have a falls risk assessment in place. This meant information about the person's current mobility needs was incorrect and did not reflect their current support needs.

Systems continued to not be robust enough to demonstrate safeguarding was effectively managed. This placed people at risk of harm. This was a breach of regulation 13 (Safeguarding Service Users from Abuse and Improper Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Care plans had been updated following our last inspection. They included information on risks which affected people's daily lives, people's skin integrity risks and weight were documented and known by staff.

Using medicines safely

- The pharmacy advice required for staff guidance on covert medicines was missing from one person's

records. This meant staff did not have all of the information needed to give the person their medicine safely.

- Medicines were administered by trained staff who had regular checks of their competency.
- Stock levels of medicines corresponded with the records in place, records also evidenced that staff regularly checked the stock levels to reduce the risk of errors.

Staffing and recruitment

- Staff were recruited safely. The service followed safe recruitment processes to ensure people were suitable for their roles. This included undertaking appropriate checks with the Disclosure and Barring Service (DBS) and obtaining suitable references. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
- There were enough staff to keep people safe and meet their individual needs. People were supported by regular staff members who they were familiar with.
- We reviewed the dependency tool in place which was used to inform staffing levels. The provider monitored and reviewed the dependency tool appropriately to ensure the staffing levels continued to reflect the needs of the people using the service.

Preventing and controlling infection

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was supporting people living at the service to minimise the spread of infection.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was responding effectively to risks and signs of infection.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

The provider ensured visiting was facilitated safely and in line with people's preference and choice. This had been risk assessed and appropriate safety control measures were found to be in place.

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.

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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 MCA 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 when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- The provider was not consistently working within the principles of the MCA. We found a locked door which restricted a person's access to their bedroom. This was not supported by a mental capacity assessment or a best interest decision. We raised this with the deputy manager who immediately arranged for the lock to be removed.
- The mental capacity assessments and best interest decisions we reviewed had been completed in line with best practice. However, there were not always records in place to show that the people involved in making decisions had the legal authority to do so.
- Staff had received training in MCA; however, the restriction we found in place, did not demonstrate staff understood how to support people in line with the Act.
- We saw evidence that applications for DoLS authorisations had been completed and submitted correctly.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs had not always been thoroughly assessed prior to them joining the service. One person joined the service during our inspection. We found their needs had not been properly assessed, risks had not been identified and there were insufficient plans in place to reduce risks to the person's safety. We raised this with the deputy manager who took prompt action to address this.

- People's care plans contained information on people's choices and preferences. We observed staff offering people choices throughout our inspection.

Staff support: induction, training, skills and experience

- Managers did not ensure that staff had regular supervisions. The provider's policy stated that every staff member would have 6 supervisions throughout the year. We found several staff had not been given this opportunity which meant staff were not consistently able to evaluate or reflect upon their practice with their manager.
- Staff had completed appropriate training which reflected the needs of the people they were providing care for. Relatives confirmed this and consistently told us they felt staff were suitably trained.
- New staff completed the provider's mandatory induction training. This included shadowing experienced staff and spending time to get to know people.

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

- We found some areas of the home needed repair. For example, some carpet was worn and damaged in the communal areas. The provider told us that this was due to be replaced as part of the home's refurbishment plan.
- We found signage in place to orientate and inform people on the ground floor; however, the second floor and loft area lacked signage to guide people in the event of a fire. We raised this with the provider who told us they would action this.
- The lounge had recently been renovated by a dementia specialist. People had been consulted and involved in choosing colour schemes and the design of the room.
- People's bedrooms were personalised with their belongings, chosen pictures and ornaments.

Supporting people to eat and drink enough to maintain a balanced diet

- People's care plans detailed the support they required from staff to eat and drink. Where people had specific dietary preferences, this was highlighted for staff to follow.
- Guidance had been sought from external health care professionals where people required additional support.
- People were provided with a choice of meals, and people and their relatives told us the food was good. One person told us, "The food is nice." A relative told us, "The food is very good and there's plenty of it. [Person] has put weight on, which is good because [person] had lost a lot of weight."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- People were supported to access healthcare. Records showed us people had regular input from their GP and Advanced Nurse Practitioner. The service worked in partnership with a GP surgery who conducted weekly reviews of people's ongoing health and wellbeing needs.
- The provider had acted promptly when there had been a concern about a person's health. Staff had contacted the relevant health professionals to seek advice and support.
- Staff knew who to make referrals to if people required more specialist support, such as speech and language therapists and dieticians.

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.

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- People's dignity was not always promoted. Relatives told us about issues they had encountered with the laundry. One relative told us, "[Person's] clothes go missing and [person] very often wears clothes I don't recognise. I have mentioned about [person] wearing other people's clothes." Another relative told us "[Person's] clothing is not always returned; I had to go and buy new. I have mentioned it to [staff]. They said it's in the house somewhere."
- We found a list containing people's confidential personal information on display in a hallway. We raised this with the deputy manager who ensured the list was removed.
- We observed staff treating people well with care and kindness; however, we found the provider's systems and practices did not always support this as not all risks had been mitigated to ensure people were safe.
- Staff had received training in equality and diversity. Care plans contained information about people's choices and personal relationships, and the support staff were to provide to ensure people's individual needs were met.

Supporting people to express their views and be involved in making decisions about their care

- People and their relatives, where appropriate, were involved in their care planning and how they wished to be supported. Care plans provided clear information for staff to follow in relation to decisions people had made.
- We observed people to be offered choices throughout the inspection. People told us that they choose what they would like to eat, and we observed people being asked what activities they would like to take part in.

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained requires improvement. This meant people's needs were not always met.

Improving care quality in response to complaints or concerns

- Relatives told us concerns had not always been resolved and kept reoccurring in relation to the service's laundry systems.
- The provider had not actioned all improvements since our previous inspection. We found ongoing issues with safeguarding and governance systems.
- The service had a complaints policy in place. We reviewed a complaint the service had received. We found this had been investigated and actions had been taken to reduce the reoccurrence of the issue raised.

At our last inspection, the provider did not do everything reasonably practicable to ensure people received person-centred care. This was a breach of regulation 9 (Person-Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, enough improvement had been made at this inspection and the provider was no longer in breach of regulation 9.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- The service had an activities coordinator in place who provided a range of activities. During our inspection, we observed several activities taking place. People had the opportunity to participate in activities in a group or on a one to one basis with staff.
- People were supported to maintain contact with people who were important to them. Relatives told us they could visit at any time.
- Special events were recognised and celebrated; people told us how much they had enjoyed these occasions.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People, and those important to them, took part in making decisions and planning of their care and risk assessments.
- People's decisions and preferences were respected by staff. This information was included in people's care plans. We observed staff offering choices and respecting people's choices throughout our inspection.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have

to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People's communication needs were identified and detailed within care plans. Care plans gave staff direction on the methods they should use to assist people with their communication such as speaking clearly and using gestures.
- Menu information had been adapted into a picture format for people to follow. This supported people in making choices about what they would like to eat.

End of life care and support

- The service was not supporting anyone who was receiving end of life care at the time of our inspection.
- People using the service were given the opportunity to express their wishes for the care they would like to receive at the end of their life.

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.

At our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

- People were at risk of avoidable harm. The provider had failed to ensure they operated effective systems to assess and implement actions following safeguarding incidents and accidents.
- The provider's oversight systems had failed to ensure improvements were made. We found there was no action plan in place to address the risks identified in a fire risk assessment review and not enough action had been taken to ensure people's safety.
- The risks we identified during our inspection in 2019 remained an issue. We found the cellar door which led to steep steps had been left unlocked twice during our inspection. We raised this with the deputy manager who told us they would remind staff to lock the door.
- Systems and processes needed strengthening to ensure staff knew what to do in the event of an emergency evacuation. The fire evacuation plan for the service lacked important detail. It did not reference the locks in place on the garden gates which would prevent the fire assembly point being reached.
- The provider's systems had not ensured the principles of the MCA were followed. We found restrictions in place had not been assessed or determined as in a person's best interests.
- The quality assurance and governance arrangements in place were ineffective. Systems and processes in place did not action findings from medicine and mealtime audits in a timely manner, so shortfalls identified continued to reoccur.
- The provider's systems had not ensured thorough assessments were carried out prior to people joining the service. We identified safety risks that had not been considered or mitigated; this placed people at risk of avoidable harm.
- The provider had not ensured people were consistently being treated with dignity. Relatives told us how concerns they had raised in relation to people's missing clothing was not properly addressed or rectified.
- The provider had not identified shortfalls of recordings in people's repositioning charts. This lack of oversight meant accurate records were not always in place to evidence the care staff had provided.
- Staff performance was not regularly evaluated. Supervision sessions did not take place as determined by the provider's policy. This meant the provider and manager did not have an overview of staff's performance and development needs.

We found no evidence that people were harmed, however the shortfalls we identified posed a risk that people could be harmed. The provider had failed to do all that was reasonably practicable to mitigate these risks. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008

The provider told us of the actions they would take to address the shortfalls we identified.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider understood their responsibility to keep people informed when incidents happened in line with the duty of candour; however, they had failed to identify and action areas of the service which required improvement.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People had regular opportunities to feedback their experience of the service and suggest improvements. We reviewed the feedback received and found this to be complimentary. When people had made suggestions, these had been actioned.
- Staff meetings regularly took place. We reviewed the minutes of these meetings and found key information was shared in relation to training compliance and upcoming events at the service.
- Relatives told us they felt updated and informed about their family member and any changes in the service. One relative told us, "We did have a relative meeting; it was very good and informative." Another relative told us, "They ring me if there are any changes or concerns. The staff, they are very good, they keep me well informed."

Working in partnership with others

- The service worked in partnership with other professionals such as district nurses and GP's to support people to access healthcare when they needed it.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems continued to not be robust enough to demonstrate safeguarding was effectively managed. This placed people at risk of harm.

The enforcement action we took:

We issued a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance We found no evidence that people were harmed, however this failing posed a risk that people could be harmed. The provider failed to ensure to all that was reasonably practicable to mitigate risks

The enforcement action we took:

We issued a warning notice