Vicarage Care Limited

The Old Vicarage

Inspection report

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08 June 2023
22 June 2023
26 June 2023

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**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 accommodation and personal care to up to 30 people. The service provides support to older people and people living with dementia in one adapted building. At the time of our inspection there were 27 people using the service.

People's experience of using this service and what we found
Although people said they felt safe, risks to people's safety had not been managed effectively. Some actions required to ensure people were protected against the risk of infection had not been completed. Although staff were trained in how to identify abuse, the provider had not always followed robust procedures when allegations were raised with them. There were enough staff to support people. People received their medicines safely.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Systems to monitor the quality and safety of the service were not effective. The registered manager did not have oversight of important information about the safety of the service. The registered manager had not always used feedback received to improve the quality of the service. The provider was aware of their responsibilities under the duty of candour. Staff worked effectively with other services to ensure people received the support they needed.

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

Rating at last inspection and update: The last rating for this service was requires improvement (published 24 February 2022) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection, although we found some improvements had been made, the provider remained in breach of regulations.

The last rating for this service was requires improvement (published 24 February 2022). The service remains rated requires improvement. This service has been rated requires improvement for the last 2 consecutive inspections.

Why we inspected
We carried out an unannounced focused inspection of this service on 25 January 2022. 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 infection prevention and control, safeguarding people from the risk of abuse and the governance arrangements at the service.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the key questions of safe and well-led which contain those requirements.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained requires improvement. This is based on the findings at this 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.

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.

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

You can see what action we have asked the provider to take at the end of this full report.

Following our inspection the provider made improvements to their infection prevention and control procedures, the processes for protecting people from abuse and the systems to monitor the quality and safety of the service.

Enforcement
We have identified breaches in relation to managing risks to people's safety, protecting people from abuse and monitoring the quality and safety of the service at this inspection.

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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

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 and provided a rating for the service under the Health and Social Care Act 2008.

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 one inspector 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 a registered manager in post.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 8 June 2023 and ended on 26 June 2023. We carried out unannounced visits to the service on 8 and 22 June 2023. Some information we needed to look at in relation to the safety of the service was not available at these visits. We arranged to return to the home on 26 June 2023 to look at the information. We contacted staff and people's relatives between 13 and 19 June 2023 to gather their views.

What we did before the 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
Most people who lived in the home were living with dementia and were not easily able to share their views with us. We spoke with four people who lived in the home and observed how staff interacted with people. We also spoke with the registered manager, administrator and with 2 members of staff. We looked around the accommodation.

We reviewed a range of records. This included 4 people's care records and multiple medication records. We looked at three staff files in relation to recruitment and training. We also reviewed records relating to the management of the service. We contacted 8 people's relatives and 6 staff to gather their views.

Requires Improvement

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. The rating 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.

Preventing and controlling infection; Assessing risk, safety monitoring and management

At our last inspection the provider had failed to assess the risk of infection and put measures in place to prevent and control infection. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Risks to people's safety had not always been assessed or managed effectively. Some actions identified in a risk assessment to manage the risk of infection had not been completed. This placed people at risk of harm.
● The registered manager did not have effective systems to identify when some environmental risk assessments were due to be reviewed. We found 2 risk assessments which had not been reviewed within the recommended timescales. The registered manager had not been aware the risk assessments had been due to be reviewed.
● Some areas of the home were not adequately maintained. The panels around one of the baths in the home were broken and not fixed to the bath. This meant it would be difficult to ensure the area was cleaned to a hygienic standard. There were sharp edges to the panels which placed people at risk of harm.
● Regular checks were carried out on the temperature of hot water to protect people from the risk of scalding. However, in some rooms where there was more than one outlet for hot water only one temperature was recorded. We could not be assured all outlets had been checked as within a safe temperature range.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection the provider arranged for the risk assessments to be reviewed and undertook to ensure all identified actions were completed. They also arranged for the bath panels to be replaced.

● People told us they felt safe in the home. Relatives told us they were confident their family members were safe.

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

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

At our last inspection the provider had failed to operate effective systems and processes to safeguard people from abuse. This was a breach of regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13.

● At our inspection in January 2022 we found an allegation of abuse had been investigated by the provider but had not been reported promptly to the local safeguarding authority or notified to us. This meant appropriate authorities did not have oversight of the investigation.
● Following the inspection we gave the provider advice about reporting allegations of abuse to the local safeguarding authority and notifying CQC promptly.
● Before our inspection in June 2023, the registered manager had notified us of an allegation of abuse which the provider had investigated. The provider had not informed the safeguarding authority or notified us promptly of the allegation.
● During this inspection a safeguarding alert was raised with the local authority. The provider was informed a safeguarding alert had been raised but did not immediately follow their safeguarding procedure to ensure people were protected from the risk of harm.
● The provider had not acted on advice given at our last inspection to improve how they responded to allegations of abuse.

The provider had failed to operate effective systems and processes to safeguard people from abuse. This was a continued breach of regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection the provider ensured prompt action was taken in response to safeguarding concerns.

● Staff were trained in how to identify and report abuse.

Staffing and recruitment
● We received mixed feedback regarding staffing levels in the home. Some staff told us there were times more staff were needed to support people and to keep them safe. Other staff told us staffing levels were adequate.

● During our visits to the home we saw there were enough staff deployed to meet people's needs and to respond to emergencies.
● Most relatives we spoke with said staffing levels appeared adequate when they visited the home.
● After we shared feedback from the inspection with the provider, they arranged to increase staffing levels at times of peak activity.
● The provider carried out checks on new staff to ensure they were suitable to work in the home. This included taking up references to verify staff were of good character and checking staff against records held by the Disclosure and Barring Service (DBS). DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Using medicines safely
● People received their medicines safely and as they needed. Staff who handled people's medicines had been trained to do so.
● The provider had introduced digital medication records and stock checks of medicines held in the home. These helped to identify any medication errors, so they could be addressed promptly.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection the provider had failed to operate effective systems to ensure the quality and safety of the service and to assess and manage all risks to people's health, safety and welfare. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- Systems to assess the safety of the service were not always effective. The registered manager did not have effective oversight of the safety of the service and people were placed at risk of harm.
- Some risk assessments had not been reviewed in the recommended timescales and some actions identified in risk assessments had not been completed. The systems to assess the quality and safety of the service had not identified these issues.
- Some areas of the home were not adequately maintained. At our visit on 8 June 2023, we noted issues with the panels around one bath. This had not been addressed when we returned to the home on 22 June 2023. We also saw staff had informed the registered manager of a maintenance issue in a person's room. The registered manager could not provide any evidence action had been taken to address the issue when we visited over a week after the issue had been raised.
- Staff did not feel well supported by the registered manager. They told us action was not always taken if they raised concerns. One staff member said, "I never hesitate to speak with [registered manager] if I have an issue that is impacting the home, but I don't feel action is always taken." Another staff member told us, "I don't believe [registered manager] is adequate and I don't feel as if [they] are very supportive." None of the staff said the service was well managed.

The provider had failed to operate effective systems to ensure the quality and safety of the service. This was a continued breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection the provider arranged for the maintenance issues to be addressed and made improvements to the systems to monitor the safety of the service.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The culture within the home did not always support good outcomes for people. Although staff were given opportunities to share their views at staff meetings, when they raised issues with the registered manager their feedback was not used to improve the service.

● Some relatives said they were asked for their views, others said they had not been asked for feedback about the service. One relative said, "They [staff] listen to me and discuss if I have any questions or concerns." Another relative told us they couldn't remember being asked for their views.

● Staff were committed to providing people with person-centred care which met their needs. People told us the staff were "lovely" and one person said, "They [staff] can't do enough for you, they are all lovely." Another person told us, "I wouldn't want to live anywhere else." A staff member said, "I believe the care team are brilliant with the residents and try their hardest to deliver the care that they require under challenging conditions."

● Staff demonstrated a good understanding of supporting people living with dementia. They followed strategies to provide reassurance when people were anxious and were patient and respectful when assisting people.

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 was aware of their responsibilities under the duty of candour. They shared information about incidents with relevant people as required.

Working in partnership with others

● Staff worked cooperatively with other health and social care services to ensure people received the support they needed. Relatives told us staff monitored their family members' health and sought prompt medical advice if required.

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 Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. Regulation 12(1)

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 The provider had failed to operate effective systems and processes to safeguard people from abuse. Regulation 13(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to operate effective systems to ensure the quality and safety of the service. Regulation 17(1)