Harbour Healthcare Ltd

The Old Vicarage Nursing and Residential Care Centre

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
The Old Vicarage Nursing and Residential Care Centre is a care home providing nursing and personal care to 47 people aged 65 and over at the time of the inspection. The service is registered to support up to 60 people over two double storey units. The Willows unit is specifically for people living with dementia. There is also a conservatory and a large garden at the back.

People's experience of using this service and what we found
People were at risk of receiving inadequate care that did not meet their needs because assessments and care plans were poorly completed and not person-centred. Records were either incomplete, inaccurate or lacked detail to provide staff with guidance on how to support people in line with their needs and preferences.

Risks to people's health and wellbeing were not assessed, recorded or manged effectively. This placed people at risk of avoidable harm.

Medicines were not always administered or managed safely. Not all staff with responsibility for administering medicines had received training or had their competency assessed. There were not always person-centred care plans in place for people's specific medicines such as insulin.

There were shortfalls in relation to the management of infection and prevention control. Staff had access to appropriate personal protective equipment, but they did not always wear it properly. Communal areas, including the main lounges and dining areas, were not always clean and well maintained. Some equipment used to support people was dirty.

There was lack of evidence to show that people were involved in decisions about their care, support and treatment. Some relatives told us there was lack of communication and involvement in care planning.

The management and leadership of the service was inadequate. Systems to monitor, assess and improve the safety and quality of service being provided were ineffective. Relatives told us they felt communication with the home could be improved.

Governance arrangements did not promote the provision of high-quality, person-centred care which fully protected people's human rights.

There was no registered manager at the time of the inspection. However, a manger had been appointed a few weeks prior to the inspection. Staff told us communication and morale were starting to improve with the new manager. Staff felt confident the new management team would make much needed improvements.

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 9th January 2021).

Why we inspected
We received concerns in relation to the management of people's health related risks, staffing concerns and lack of leadership. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection. The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

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

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 registered provider has been responsive to concerns noted during the inspection and has started to take action to make improvements and promote safety within the home.

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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment and good governance.

Please see the action we have told the provider to take at the end of this report. 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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service.

This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

The Old Vicarage Nursing and Residential Care Centre

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 Care Act 2014.

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 three inspectors.

Service and service type
The Old Vicarage Nursing and Residential Care Centre 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 service did not have a manager registered with the Care Quality Commission. This means the provider is legally responsible for how the service is run and for the quality and safety of the care provided. A manager had recently started at the service.

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. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us 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 all of this information to plan our inspection.

During the inspection
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.

We spoke with two people who used the service and six relatives about their experience of the care provided. We spoke with 12 members of staff including the manager, clinical lead, senior care workers and care workers.

We reviewed a range of records. This included seven people's care records, and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at rotas and training records.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

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

- People were exposed to risk of harm due to a lack of person-centred risk assessment. Risk assessments were either not completed, not accurate or reflective of people's current needs, or detailed enough to guide staff on safely supporting people.
- Where people were supported with bedrails, there were no risk assessments in place to ensure risks to people had been assessed and managed. Bed rails checks were not always completed to make sure they were safe.
- People with specific care needs, such as diabetes, did not always have care plans in place to guide staff on how to safely support them.
- People were at risk of not having their nutritional needs met. Food and fluid monitoring were not completed adequately by staff. Records showed people had been offered less than 1000mls per day regularly, including through a period of extremely high temperatures. One person, with a health condition that meant their fluid had to be restricted, was often given more than their limit. Concerns regarding this had not been raised appropriately.
- People were at increased risk of pressure sores as care plans did not always reflect the support they required. Staff told us one person required 2-hourly repositioning, but records indicated this had not happened.
- Personal emergency evacuation plans were not always completed accurately or fully. This placed people at risk of harm in the event of an emergency situation.
- Accident and incident analysis was not always robust enough to prevent further incidents. Analysis that had been completed was not effectively shared with managers and staff to ensure identified improvements could be implemented.

There was a failure to robustly assess risks relating to the health, safety and welfare of people. Lessons had not been learnt to prevent repeat incidents. This placed people at risk of avoidable harm. This was a breach of regulation 12 (Safe care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection to the concerns identified.

Using medicines safely

- Medicines were not always administered safely and in line with best practice and any prescriber instructions. This placed people at avoidable risk of harm.
- Covert medicines were not being given in accordance with the Mental Capacity Act 2005. For example, for

one person living at the home staff did not have clear guidance on what medicines were to be administered covertly. There was also no advice from a pharmacist about how the covert medicines could be given safely.

● Not all staff had their competency for the safe administration of medicines assessed. The clinical lead agreed to complete these immediately.

Medicines were not administered or managed safely. This was a breach of regulation 12 (Safe care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● There were shortfalls in relation to the management of infection and prevention control (IPC). Whilst staff had access to appropriate PPE (personal protective equipment) they did not always wear it properly.
● Communal areas, including the main lounges and dining areas, were not always well maintained. There was evidence of dust build up, and equipment cluttered in corners making effective cleaning difficult. There were no records to show cleaning of these areas had taken place.
● Some equipment used to support people was dirty. One staff member said, "Equipment is wiped down between each use but think cleaners clean them. Carers just wipe them down." There was no evidence equipment was fully cleaned.

Systems and processes were not effective to prevent the control and spread of infection. This was a breach of regulation 12 (Safe care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff and visitors were tested for COVID-19 in line with national guidance.

Systems and processes to safeguard people from the risk of abuse
● Staff had received appropriate training and were clear on the potential signs of abuse and how to raise any concerns they might have.
● We received mixed feedback form relatives about how safe their loved ones were. One relative said, "I'm not happy. In fact, I have complained numerous times. It's been terrible. [Person] lost a lot of weight and its down to lack of care." Another relative said, "I'm absolutely amazed. I've been so pleased. [Person] is getting fed, is clean and is well looked after. [Person] mood has improved."

Staffing and recruitment
● Staff recruitment was undertaken in a safe way. However, we noted inconsistencies in reference request processes across the staff records we looked at.
● We received mixed feedback about whether there were enough staff at the service. Most relatives felt there were enough staff but reported a lot of these staff were new and still getting to know people. However, some relatives felt there were always issues with staffing levels and they were constantly short staffed.
● We looked at staff rotas and observed staffing levels during our inspection. We saw that there were enough staff to meet people's basic needs. However, staffing levels were not calculated effectively as information regarding people's dependency levels was often out of date and inaccurate. We have reported on this in the well-led section of this report.

Inadequate

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The provider had introduced electronic records in April 2021 to improve quality and oversight. However, this had not been implemented effectively. Not all records were available on the electronic system and information in paper files was either missing or not reflective of people's current needs.
- People were at risk of receiving poor care because risks to their safety and well-being were not assessed and managed appropriately to protect them from harm.
- Records were not of good enough quality to guide staff on how to meet people's needs safely in a person-centred way. This meant there was a risk care and support provided may be unsafe.
- Processes to determine the deployment of staff were ineffective because records were poorly maintained. People's assessment of dependency was often out of date and inaccurate.
- Systems to assess, monitor and improve the quality of the service had failed to identify and address the issues highlighted in this report. This left people at risk of harm.
- Systems were not robust enough to ensure learning from incidents was implemented to further reduce risk to people.
- Governance arrangements did not promote the provision of high-quality, person-centred care which fully protected people's human rights.

There were insufficient and inadequate systems in place to monitor and improve the quality of the service. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Not all staff and managers were aware of their roles and responsibilities. Some roles in the service have not been covered whilst recruitment into vacant posts took place.
- The ratings from the last inspection were not displayed in the home as required. We raised this with the provider during the inspection and this was addressed immediately.
- There was no registered manager in place. The provider had recruited a home manager who was in post at the time of the inspection.
- There was a range of regularly reviewed policies and procedures in place to help guide staff.

Working in partnership with others.

● There was a lack of effective work with other agencies to support people's health needs.
● People were at risk of not having their needs safely met. Guidance provided by professionals regarding people's care needs had not always been appropriately recorded.
● Some professionals who visited the service told us communication needed improving.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● There were systems in place to obtain feedback from people and their representatives about the running of the service. However, most relatives told us they had not been asked to provide feedback on their experiences of the care provided.
● Most relatives said they had not been involved in care planning or reviews of care plan information. Some relatives also said they were not kept updated on their loved ones wellbeing. Comments included, "It's terrible communication. I have no confidence in them to improve. It's very impersonal," and "In lockdown getting through on phone was dreadful. [Person] got infection and ended up in hospital. We couldn't get through to the home."
● Staff told us concerns with communication and low staff morale were starting to improve with the new manager.

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 duty to share information in an open, honest and timely manner. There was a policy in place regarding this.
● We found the provider receptive to feedback about the shortfalls found during the inspection.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Processes to monitor and improve the safety and quality of the service were inadequate. Information form incidents was not used effectively to ensure lessons were learnt.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's health and wellbeing were not assessed or managed adequately. This placed people at risk of harm. Medicines were not managed safely. Infection, prevention and control procedures were not robust enough to demonstrate the risk of spread do f infection was being managed effectively.

The enforcement action we took:

Warning notice