Barchester Healthcare Homes Limited

Vecta House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on the 10 and 18 May 2018 and was unannounced; at time of the inspection 48 people were accommodated at the service.

Vecta House is a 'care home' and is registered to accommodate up to 54 people. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The CQC regulates both the premises and the care provided, and both were looked at during this inspection. This home provides a service to older people with dementia or mental health needs.

The home had a manager who had recently taken up this position; they were not yet registered with the Commission. 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.

We last inspected the service in April 2017 and rated it 'Requires Improvement' overall. We identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe care and treatment, good governance and safeguarding service users from abuse and improper treatment. At this comprehensive inspection we found eight breaches of regulations. All three regulatory breaches from the last comprehensive inspection in April 2017 were repeated. There were systemic failings identified during this inspection that demonstrated a significant deterioration in the quality and safety of the service since its last comprehensive inspection.

The provider had failed to ensure effective oversight of service provision. Quality and safety monitoring systems were ineffective in identifying and directing the service to act upon and mitigate risks to people who used the service and ensure the quality of service provision.

Following the inspection we wrote to the provider informing them of our concerns and requiring them to send us weekly action plans detailing how they were addressing the areas of immediate concern. These have been received as required. The provider has also voluntarily agreed not to admit new people to Vecta House until they are satisfied that all necessary action has been taken and people will be safe.

Statutory notifications are information about specific important events the service is legally required to send to us. We found that these had not always been made as required.

Records relating to the management of the service had not been effectively reviewed and assessed; we found errors and discrepancies that had not been identified by the quality assurance systems in place.

Care plans were not consistently person centred and lacked detailed guidance for staff to ensure people received care in a person centred and safe way. Risk assessments that related to peoples health, safety and

the environment did not ensure that all risks were effectively assessed. Action had not always been taken to reduce identified risks to ensure the safety of people. This exposed people to a risk of neglect and unsafe or inappropriate care or treatment.

People were not always treated with dignity and respect; we observed occasions when staff treated people without compassion and kindness. People living with dementia were not always treated as adults.

Staff said they knew how to prevent and report abuse. We were concerned however that staff practice which amounted to omissions of care had not been considered as neglect by them.

There were not enough sufficiently skilled staff to meet people's needs. Staffing needs had not been fully assessed and there was a high reliance on agency staff; we observed that the staff on duty lacked the skills and knowledge to care for the people in residence. People therefore did not receive person centred care.

Staff received training and supervision however we were not assured of quality of this given the widespread failings found at this inspection.

The provider had appropriate staff recruitment procedures however these were not followed; not all employment checks were completed before staff started working with people.

Emergency evacuation procedures and arrangements were flawed and staff were unprepared for emergency evacuations.

The administration, safe management and security of medicines was not in line with best practice or followed the provider's policies at all times. Medicines were not always administered as prescribed and there was a lack of lack of recording of why 'as required' medicines had been given and the effectiveness of their action. This information would be needed to determine if the PRN medicines had resolved the problem or if alternative medicine or action was required.

Records of the assessment of people's ability to make some informed decisions had not been undertaken as required. The principles of the Mental Capacity Act 2005 were not being applied in respect of best interest decisions to provide care or use restrictive practices.

Staff, people and visitors gave varied feedback about the service. Our observations of how care was provided to people was reflective of the varied feedback. Staff were positive about the recent change in management.

There was a complaints policy in place. People and relatives knew how to raise concerns.

We found eight breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any

key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

Risk assessments that related to people's health, safety and the environment did not ensure that all risks were effectively and competently assessed. Action had not always been taken to reduce risks to ensure the safety of people.

Emergency evacuation planning and procedures were not robust. Staff were not adequately prepared for emergencies.

Staffing was not planned effectively, there were not enough suitably skilled staff to meet people's needs.

Staff had received safeguarding training and knew how to report abuse.

Medicines were not managed safely.

Recruitment practices were not robust and had not ensured that all pre-employment checks were completed as required.

Is the service effective?

Requires Improvement

The service was not always effective.

Where people lacked the ability to make decisions, such as those relating to care, best interest meetings or discussions had not always been held to ensure their legal rights would be assured. Where necessary Deprivation of Liberty Safeguards (DoLS) applications had been made.

We were not assured that people always received the necessary medical and personal care that they required. People received a varied diet but were not always supported appropriately to eat and drink.

Staff felt supported and formal supervision was now taking place. Staff received training however they did not always put this into practice.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always cared for and treated with dignity, respect, kindness and compassion.

Not all staff communicated with people in a meaningful way and people were not always informed about what was to happen to or around them.

People were supported to maintain valued relationships.

Confidential information was maintained securely.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans and care delivery was not consistently person centred and there was contradicting information within care plans.

Information about people's end of life care preferences and wishes had not been recorded meaning these may not be known and met.

Activities providing both mental and physical stimulation were provided via activities leaders.

A complaints procedure was in place which ensured complaints were responded to correctly.

Is the service well-led?

Inadequate

The service was not well led.

A quality assurance process was in place, however, this had not identified the areas of concerns we found. The provider had failed to ensure improvements required following the previous inspection in April 2017 were sustained over time and we identified additional areas of concern at this inspection.

Statutory notifications had not been made as required.

Staff were positive about the recent management changes which had occurred and felt valued by the manager.

Vecta House

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 was planned to check 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 10 and 18 May 2018 and was unannounced. It was completed by two inspectors, a specialist advisor in nursing care 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.

Before the inspection we reviewed information we had received about the service, including previous inspection reports, the provider's action plan and notifications. Notifications are information about specific important events the service is legally required to send to us. We also considered information the provider sent us in the Provider Information Return. 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 spoke with four people who used the service and 12 family members or friends of people who used the service. We spoke with the manager, the provider's area manager, the provider's quality manager and the provider's health and safety manager, five registered nurses, eight care staff, two agency care workers, two activities coordinators, an administrative assistant, a maintenance worker, kitchen staff and two housekeepers. We received feedback from two health or social care professionals who had contact with the service.

We looked at care plans and associated records for nine people and records relating to the management of the service, including: duty rosters, staff recruitment files, records of complaints, accident and incident records and maintenance records.

We observed care and support being delivered in communal areas of the home.

We last inspected the service in April 2017 when we rated the service 'Requires Improvement' overall and

identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service safe?

Our findings

At our last inspection, in April 2017, we identified a breach of Regulations 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Procedures to administer medicines had not always ensured that people had received these as prescribed.

At this inspection, we found some improvements had been made; systems were in place to ensure that prescribed topical creams applied as prescribed. Once opened these were dated meaning they would not be used beyond their safe to use by date however we saw one prescribed topical cream in use beyond the stated safe date. Despite some improvement there continued to be failings with regards to medicine management.

People were not always supported to receive their medicines safely and as prescribed; the Medicine Administration Record (MAR) for one person recorded they were asleep at 22.30 hours therefore an antibiotic for a urine infection had not been administered. The person was not offered this medicine later during the night. However the person's fluid chart recorded that at 22.30 hours the person had been awake and had drank 200mls of juice. We identified this inconsistency with the manager who undertook to investigate the reason and establish why the antibiotic had not been offered when the person was awake. For people prescribed 'as required' medicines (PRN), we found there was usually clear information about when and how these medicines should be given. However, there was a lack of recording of why these had been given and the effectiveness of their action. This information would be needed to determine if the PRN medicines had resolved the problem or if alternative medicine or action was required.

Medicines were not being managed in accordance with the provider's medicines policy and procedure. The provider's policy stated that there should be no common supply of medicines however fluid thickening powder was being supplied via a bulk (common) procedure.

The provider's medicine policy was also not being followed in respect of medicines administered covertly; hidden within food or drink, without the person's knowledge. The provider's policy stated that this should be administered following a best interest decision involving the prescriber and pharmacist. We saw that a nurse prescriber (who would have limitations on what they can prescribe) had signed the best interest decision. The best interest form dated November 2017 had not been fully completed and stated that it had been faxed to the pharmacist in February 2018 but there had been no action to chase this up with the pharmacist. The form contained a box for a review date but this had not been completed. Nationally recognised guidance (NICE) specifies that the person's GP should be involved in decisions about the administration of covert medicines. Therefore neither the provider's policy or NICE guidance were being followed.

Risk assessments had been completed for identified individual risks, together with action staff needed to take to reduce the risks. However staff did not always have the correct guidance to manage all risks to people safely. This put people at risk of receiving unsafe and inappropriate care. For example, one person was assessed as at high risk of pressure injuries and their care file identified that the risks were reduced as

the person was supported to walk four times a day relieving pressure on their vulnerable areas. The risk assessment had not been updated to reflect that the person was no longer able to walk and equipment was used for repositioning. Furthermore care records did not reflect that repositioning was being undertaken on a regular basis to reduce risks to the person's vulnerable areas.

Staff did not always ensure people's safety as they failed to apply risk management guidance effectively. Some people had been assessed by a Speech and Language Therapist (SaLT) as requiring their food in a pureed (no lumps) format due to their risk of choking. However, nurses were administering tablets and capsules to these people placing them at high risk of choking. No additional risk assessments or best interest decisions had been completed or further guidance sought from SaLT meaning these people were consistently being placed at risk of choking on medicines which were not in a suitable medium for them to swallow safely.

Where thickened fluids were recommended, we saw people were not always receiving the correct consistency as detailed in SaLT guidelines. We saw one person who should have been receiving fluids at a stage two thickness was receiving these at a stage three thickness. We raised this with the care staff member and nurse who was present. Initially the care staff member did not move to amend the fluid thickness until the nurse told them not to give any more to the person until it was of the correct consistency.

Some people were at risk from the actions of others. We asked why a person cared for in bed and who would be unable, due to their physical disability, to leave the bed unaided required movement alert equipment which we saw beside their bed. We were informed that this was to alert staff if other people entered the person's room and approached the person. The equipment in use was a mat approximately the size of a door mat. Staff confirmed that people could easily walk around the mat and still approach the person meaning the system in place would not protect the person.

General risk assessments were also in place to address some but not all risks posed to people. These had been produced by the provider for all their locations but had not been individualised to reflect the situation at this service meaning that risks were not being managed as per the risk assessments. For example, in one part of the home the lounge dining area had a kitchenette area. A risk assessment dated 01/05/18 related to a cordless kettle however the area had a hot water boiler/urn and not a kettle. Within each bedroom we saw a cupboard with a key attached by a chain or left loose on top of the cupboard. We saw these cupboards contained toiletries and prescribed topical creams. There were no individual risk assessments in respect of these cupboards and the provider's general risk assessment dated 1/5/18 for the storage of toiletries did not cover these situations. The general risk assessments had not been signed by the person who had completed these and were not reflective of practices in the home meaning risks were not being assessed and managed appropriately.

When accidents and incidents occurred the provider's procedures were not always followed to ensure that these were investigated and action taken to prevent recurrences. The manager explained that staff were required to complete an accident/incident form and that this was reviewed by the manager for investigation. We saw in one person's care file that a person who was cared for in bed had been noted to have a graze to their knee. However, there was no information as to how this had been caused or action that could be taken to prevent this occurring in the future. The manager confirmed that they had not been informed of the injury and staff had therefore not followed the required procedure.

Staff had not followed best practice guidance where people had experienced an unwitnessed fall. This states that a head injury should be assumed and medical advice and regular monitoring of the person

should be completed in order to identify early signs of deterioration. Whilst viewing records of accidents and incidents we saw that the only occasions when specific observations were undertaken was when a person was known to have injured their head. On all other occasions where an unwitnessed fall had occurred there was no reference to monitoring the person for deterioration secondary to a head injury.

Where people required support with moving and repositioning we saw this was usually completed in an appropriate and safe way. However, we also observed a staff member assist a person to stand by lifting them under their armpit and pulling up on the back of their trouser waist band. This was an unsafe manoeuvre and placed the person and staff member at risk of injury.

All of the examples above demonstrated that the provider was not managing risks to people effectively, this exposed people to a risk of neglect and unsafe or inappropriate care or treatment.

Some people were cared for in bed all the time and were at risk of developing pressure injuries; we saw that special pressure-relieving mattresses had been provided. Staff understood how to adjust the mattresses and there was a clear process in place to help ensure they remained at the right setting according to the person's weight.

People were at risk in the event of an emergency as staff were unprepared and did not follow emergency procedures. During the inspection there was an unplanned fire alarm. We saw a person seated in a chair that was positioned so that the automatic fire door could not close. In another part of the home another fire door could not close until care staff moved a person's table. At the front entrance where various staff who had responded to the alarm were gathered we saw that permanent staff did not act until the provider's health and safety manager who was visiting the home suggested that "Someone should go to see if there is a real fire." Other staff had just stood around and looked at the fire board. In another part of the home people and care staff remained calm, however staff did not react in a purposeful way and one staff member was overheard saying "What shall we do, do you think they will tell us what's going on?"

In the event of a fire evacuation people may have been placed at risk by blocked and unsuitable exits. We looked at how people, staff and visitors would have exited the building had this been a real fire. We saw that fire exit signage was incorrect and some exits were blocked or unusable. For example, one fire exit sign directed people into a cupboard, another to an area used to store wheelchairs and equipment. One fire exit directed people out over an area of decking which was unsafe due to rotted wood. Once outside another exit past the kitchen was blocked by chairs and food trolleys and then by coded padlocks on gates into the car park. Staff were unaware of the code for these coded locks.

We looked at the training matrix for all staff employed at Vecta House. The matrix showed that some staff were out of date with annual fire safety training, including 'evacuation drills'. The provider had not ensured that staff would be competent in the event of an emergency evacuation.

Personal emergency evacuation plans were not up to date. Each person had a personal emergency evacuation plan detailing the support they would need if the building needed to be evacuated. This information was also included in an emergency bag however we saw that the information in the emergency bag had not been updated when a new person had moved into the home the week before the inspection. Their room number was still showing as empty meaning rescue services would not expect to find a person in that room and therefore not check it. The provider's area manager took action to rectify these issues and on the second day of the inspection we saw action had been taken however had there been a real emergency requiring evacuation then people would have been placed at risk.

The failure of the provider to ensure that the risk to people was minimised in the event of an emergency or evacuation people meant that people had been put at significant risk of harm. We have reported these concerns to the local fire service.

The service had an infection control policy in place, which was produced by the provider for all of their service locations. The service had received support from the Head Housekeeper of a sister location in order to share best practice around infection control procedures. They described the action they were taking to improve cleanliness and the organisation of cleaning staff at Vecta House. Staff had completed infection control training, had access to personal protective equipment (PPE) and wore this however we found that people were not always protected from the risk of infection. We observed occasions when staff did not follow good infection control procedures. For example, we saw a staff member changing a person's bed linen, around the floor of the room we saw used sheets, towels, blankets and nightwear. The manager was present and spoke with the staff member who then gathered the used linens together in the bedsheet and carried it to the laundry room. The items should not have been on the carpet and should have been placed into a laundry bag before being transported to the laundry room. The staff member had increased a risk of cross contamination by placing the items on the carpet and then carrying them openly through the home. On another occasion we saw a staff member assisting a person to eat a banana. The staff member had a disposable glove on one hand but was using their non-gloved hand to break the edible part of the banana to give in bite sized pieces to the person. This was contrary to best practice for the handling of food.

The home appeared clean although we noted an unpleasant incontinence related aroma in various corridors and some communal areas of the home coming from the carpets. The continuing aroma demonstrated that the carpets were not thoroughly clean. The manager explained that the carpets had been deep cleaned however this had not eliminated the odour and there were therefore plans to replace these.

The failures to ensure the proper and safe management of medicines, appropriate infection prevention and to ensure risks relating to the safety and welfare of people using the service were assessed and managed were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Before the inspection we received information that the home did not always have enough staff. We were told that on occasions some people had not received their required 1-1 support to ensure their and other people's safety. The manager said that this situation was now resolved and through the use of agency staff individual support was now always provided. We saw this was the case during the inspection. However the manager told us the home did not have sufficient permanent staff and was actively working to reduce the use of agency staff which they identified as being an area that needed improvement.

Visitors and relatives raised concerns about staffing levels at the home. One visitor told us "The main problem they have here is staff, I find there is not enough." Other visitors raised concerns about the usage of agency staff and said "I don't think the agency staff are taken to one side and shown what to do" and "Permanent staff are better because they can spot issues early on and prevent things from escalating. Another visitor said "Staff are overworked and there are not enough of them. They are always up against time." Most staff also raised concerns about the amount of agency staff working at the home and their knowledge and felt this was having an impact on their workload and meeting people's needs. One staff member said "It's all been a bit of a mess for the last few weeks – we've been playing catch up a lot."

The manager told us staffing levels were based on the outcome of using the provider's staffing dependency assessment tool. However when we viewed people's care plans, we found that this had not been completed

to give an outcome of recommended staffing required. We were therefore unable to identify how staffing levels had been reached. Although care staff told us they felt there were enough staff most of the time we identified occasions when people's needs were not being promptly met. At one time we were in area for 13 minutes with no staff present. A person was visibly unsafe on a chair and the area manager who had come to talk with us went to support person. If they had not intervened the person would have been at high risk of a fall. In addition to this the high usage of agency staff combined with the widespread failings found at this inspection including poor evacuation procedures and poor risk management demonstrated that there were not enough suitably skilled and competent staff available to meet people's needs.

The failure to ensure that there were enough suitably skilled staff to meet people's needs was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had safe recruitment procedures in place; these had not however been appropriately followed. The recruitment procedures included seeking references, obtaining a full employment history and completing checks through the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions by disclosing any previous convictions held by the applicant. The manager told us that where new staff had been employed, they would always telephone for references, to verify directly that they had been sent the reference. Where applicants had gaps in their employment, we saw letters had been sent to follow this up and confirm the reason for this. As part of the interview process for new staff, the manager told us that potential candidates were walked round the building and introduced to people living at the home. This provided the manager with the opportunity to look for positive interactions with people.

At the time of the inspection the manager was covering a number of shifts each week with agency care staff. There was a process in place that before any agency staff commenced work at the home the agency should send details of the staff member including photograph and confirmation of DBS and training completed. This would ensure that the correct staff member with the necessary checks and training completed attended for work. However, we saw that this information was not always received until after the staff member had worked in the home. For example on the second day of the inspection we spoke with an agency staff member who told us this was their first shift at the home. We asked for their information details but were told this had not been received. This was received in the afternoon after the agency staff member had completed their shift. The failure to have all necessary information in place before staff commenced work placed people at risk as staff may not have been suitable to work with vulnerable people.

The failures to ensure that all necessary recruitment checks were undertaken was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a policy and procedure regarding the safeguarding of people. The policy stated that all allegations of abuse should be reported immediately to the local authority safeguarding team. Records confirmed that the manager had reported incidents appropriately to the local safeguarding authority where required. Staff had completed safeguarding training during their induction with the service and also as part of their annual refresher training. Staff confirmed their understanding of the role of the local authority safeguarding team; however we could not see that contact numbers were readily available for staff. We spoke with staff about their responsibilities in the event of a safeguarding incident. They were aware of actions they should take including reporting concerns outside the home to the local authority safeguarding team. One staff member said "If there is anything different, if I've not seen it before, I will report it." However we were not reassured as staff had not identified the poor staff practice we observed as safeguarding issues and therefore had not acted to ensure people were protected from the risk of abuse. Family members we spoke with told us they had raised safeguarding concerns about the way their relatives were cared for as their needs had not always been met.

Other environmental risks were managed effectively. Gas and electrical appliances were serviced routinely. A fire safety risk assessment had been completed in the previous year. This had identified additional safety measures, all of which had either been implemented or was in the process of being implemented. An assessment of Legionella risks had also been completed by an external company and where necessary action was and had been taken to minimise the risks posed by this.

The service had recently received a food hygiene rating of 3 stars following an inspection of the kitchen. The manager informed us that all actions recommended by the food hygiene inspection team had now been completed, and a temporary chef was currently working in the home pending the arrival of a new permanent chef.

Requires Improvement

Is the service effective?

Our findings

At our last inspection, in April 2017, we identified breaches of Regulations 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider's procedures had not been followed when restraint was used meaning this may have been unlawful and placed people at risk of harm. At this inspection we were told nobody was requiring physical restraint by staff. The manager was clear about the actions they would take should this be necessary to protect the person or others.

Some restrictive practises were in use such as the use of bed rails or movement alert equipment. Where this was in use Mental Capacity Act (MCA) and best interest decisions were not consistently used. For example, one care plan stated bed rails were in place for a person and a best interest risk assessment had been completed for this, however no other Best Interest / MCA assessment were evident for other care related tasks which the person would not be able to consent to. On the first day of the inspection we identified that there were no MCA assessments and where necessary best interest decisions around people receiving medicines as prescribed for them. The manager confirmed that the majority of people lacked the mental capacity to fully understand the need for each medicine they were receiving and therefore were unable to give informed consent for the medicines.

There was a best interest policy in relation to medicines in the medicine folders. On the second day of the inspection we saw best interest decision had been completed in all care files viewed in relation to receiving medicines. These had been completed on the provider's mental capacity and best interest form which if used correctly would have ensured each person's legal rights were protected. However, the forms contained limited individual information and none showed evidence of consultation with family members, or anyone other than the two staff who had completed all the assessments.

Relatives of some people living at Vecta House had the legal authority under a lasting power of attorney (LPA) to make decisions on behalf of people including decisions relating to their health and welfare. The manager was unable to tell us who these people were as they said there was no central list of these. We were told that copies of LPA's were held within the administration office but without checking all files it would not be known who had an LPA in place.

The failure to ensure that, where people lacked the capacity to give informed consent, action was taken to comply with the Mental Capacity Act when providing care was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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). The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The manager told us they were unsure which people had a DoLS in place or if there were any conditions attached to these. They were aware of one person whose conditions were being met. Within care files we saw that some DoLS authorisations had been made and others were awaiting

assessment by the local authority. We also saw in another care file that the DoLS had been reapplied for when necessary. Although staff understood what DoLS were they could not name specific people where these were in place. The inability of the manager and staff to be aware of DoLS in place and conditions which may be applied to individual people meant the monitoring of DoLS's and conditions could not occur and people's legal rights may not be ensured.

People did not receive effective care that was individual to their identified health and personal care needs. Care plans did not always provide the necessary information to enable staff to be effective, this put people's health at risk.

We were not assured that people's person centred health care needs were being met safely. We spoke with a nurse about how they supported a person with a diagnosis of diabetes. Records showed their blood sugars were high on a regular basis. We asked how this was being managed and if external health professionals such as a diabetic nurse or GP were involved or aware of this. We also asked about regular screening which is normally completed for people living with diabetes had taken place. The nurse did not seem to know and was unsure of the regular screening we talked about.

Within another care plan we found information as to how a particular medical condition should be managed was non-technical and vague. This specified measuring the person's abdomen when "appearing to get big", and when abdomen reaches 100cm they need urgent hospitalisation. However there was no information as to what action to take before the urgent hospitalisation was required to prevent the person's condition becoming urgent.

One person's care plan stated that a seizure chart had been introduced within their daily record folder, and should be completed regularly as the person had started to experience involuntary movements. We discussed this with two care staff, one of which was providing direct support to the person on the day of the inspection. Neither care staff was clear on their responsibilities around this, or that there was a specific chart in place they needed to complete. We saw the chart was not completed and read in medical records that a medicine had been discontinued as there had been no involuntary movements recorded. This meant a medical decision was made based on the lack of recording on a form staff were unaware they should be using.

On the second day of the inspection we became aware that there was a medical emergency occurring and paramedics had been requested to attend the home. We went to the area of the home the person was in and were informed of the situation. We saw the person had been left alone with no staff in attendance. The person was clearly anxious and looked scared and should not have been left unattended at this time. We raised this with the nurse who directed a care staff member to stay with the person. They were not informed of what the medical emergency was and therefore were unaware of what was expected of them. The failure to ensure the person was supported correctly pending the arrival of paramedics placed the person at risk that should their condition deteriorate appropriate action would not have occurred. Subsequently another nurse took over from the staff member and provided appropriate care and emotional support for the person.

We were also not assured that people were receiving all personal care they required. This was also raised by a relative who informed us that when visiting they had identified the person smelt of stale urine at 17.45 and they informed staff. However, no staff supported the person and changed the continence pad until 18.45. The relative informed us the person had developed a sore area due to urine burns. We saw in another person's care plan they should have their incontinence pad checked every four hours, however there was no documented evidence to confirm this was being done. We raised this with the Clinical Lead who agreed that

the recording was not sufficient to reassure them that this was completed. Another family member identified to staff in a review meeting in April 2018 that the person was frequently declining teeth cleaning and asked what other action could be taken to support the person with oral hygiene. However, staff and monthly reviews of care records had not identified this until the relative raised the issue.

Staff did not always ensure people received the support they required at meals times. For example, we saw a person sat with a bowl of luke warm porridge and a cup of tea in front of them. The person was not eating and no staff were present to encourage them to do so. We asked the manager about this and they directed a staff member to support the person. In another part of the home at breakfast time we saw a person sat with a plate of sandwiches and drink in front of them that they were not eating. Both the drink and sandwiches were still present untouched 45 minutes later. At lunch time we observed a person eating their lunch meal with their fingers as no staff were present to encourage them to use cutlery.

We noted there was no drink in a person's bedroom, their visitor said "We have to ask". The person would have not have been able to request drinks themselves. Another relative told us how when they had visited the previous weekend staff had forgotten to provide afternoon tea for two people seated in a quieter lounge. This demonstrated that on occasion staff did not always meet the needs of people who were unable to speak for themselves.

The failure to ensure people received person centred care, support and care planning is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who were able to speak with us said they received a varied diet and enjoyed the food at the service. Lunchtime appeared calm and relaxing. Dining room tables were laid up with a menu displayed on each table. People were asked if they would like to be taken to the dining room to sit and have their lunch, and care staff did this patiently with people at their own pace. People were asked where they would like to sit and if they would like a starter before their main meal. There were two options for the main meal (fish or chicken), both were presented well. One person said "That looks nice" when entering the dining room and seeing other people already eating. We also saw that care staff were taking other options to people who remained in their rooms on a tray, such as sandwiches. Another person said "The food is alright not like some places. There is a nice selection. I have breakfast in bed. It is easier for them to bring the food to you rather than taking you to the food."

A comprehensive training programme was in place for all staff. This was coordinated by a training manager, who also delivered some of the training. A staff member told us, "[Trainer] is really good, he's brilliant. [Trainer] makes it interesting." New staff completed an induction into their role. This included time spent shadowing, (working alongside experienced staff) until they felt confident they could meet people's needs. Staff who were new to care were supported to complete training that followed the standards of the Care Certificate. The Care Certificate is an identified set of standards that health and social care staff adhere to in their daily working life. Experienced staff received regular training in all key subjects. Staff were required to complete an annual refresher which takes place regularly throughout the year. This covered areas such as fire safety, food hygiene, manual handling and infection control. The training manager completed observations of staff at Vecta House. We saw records of observations completed and follow up discussions that were held with staff members, to talk about areas of improvement. However, this had not ensured that staff always provided care and support appropriately to meet people's needs as described above.

Staff were supported in their role. They described the manager as supportive and approachable. The manager explained that they were completing formal supervision sessions with all staff and had identified that these had not been occurring on a regular basis during the preceding year. We saw records of recent

supervisions that had taken place with the manager, which documented areas of feedback and performance improvement for each staff member.

In addition, each staff member received an annual appraisal to assess their performance over the past year. Nurses were supported to undertake additional training and continued professional development to meet the requirements of their professional registration.

Despite training and supervision taking place we received feedback throughout the inspection and as detailed throughout this report that staff were not adequately skilled and competent. One relative stated that staff did not all have the necessary skills to meet people's needs. They said "Sometimes they are just sat there, not engaging. I find some of the younger ones [staff] don't know how to engage."

There was some good practice taking place. Nursing staff were able to explain correctly the actions they would take if a person complained of chest pain or what may lead them to suspect a person had a urinary tract infection. We also saw that people had access to a visiting optician and where indicated people had been provided with new glasses. Nursing staff had also consulted with an external tissue viability nurse to ensure they were providing appropriate care in respect of a person with a wound.

When people transferred to hospital or to another care setting, staff used specially designed forms to help ensure all key information about the person's needs was passed on. We also saw that a staff member accompanied a person who was admitted to hospital in an emergency during the inspection. This would help ensure appropriate information was passed on to the hospital team and provided emotional support for the person in a complex and unfamiliar situation. These arrangements helped ensure continuity of care for the person.

Vecta House was built as a care home and was suitably designed to support the needs of people living there however not all areas of the home were well maintained. The manager told us that the home was scheduled to be refurbished later in the year with the providers aiming to ensure it complied with all relevant guidance on ensuring a suitable environment for people living with dementia. We saw some signage was in use to support people to navigate around the home however other aspects of dementia best practice environments was not in place. People could access some outside space and a pleasant sensory garden was available. We were informed that the temperature within the home could sometimes exceed comfortable safe limits and were provided with copies of photographs of thermometers showing this. The area manager was aware of this which had happened the weekend prior to the inspection and was investigating how this had occurred and looking at action that could be taken should this situation occur again.

Requires Improvement

Is the service caring?

Our findings

People were not always treated with kindness and compassion. Throughout the inspection staff were task orientated and smiled infrequently around people.

When there was an unplanned fire alarm we saw staff made no attempts to reassure people and spoke together discussing what they should do. During the inspection we observed limited evidence of caring either in the physical delivery or in care planning. For example, a person was brought into a lounge by a staff member. The staff member did not ask the person if they were comfortable or provide them with a drink or magazine. The staff member just left.

With the manager we visited some people who were cared for in bed all the time. In one room we saw that there was virtually no furniture, there was a hole in the wall that had not been repaired, and although there was a blind at the window there were patches of Velcro stuck to the curtain rail but no curtains. The room appeared shabby and uncared for. The manager could not explain why the room was presented in this way which was not valuing of the person and appeared bleak and barren. Staff told us that the person had previously used furniture in a way that had placed them at harm. The person's care plan did not include this information or any actions taken to support the person or make their environment more positive. The manager later confirmed that the person was no longer mobile and therefore there was no reason for their room to be devoid of furniture and this had now been reintroduced to their room and the hole in the wall repaired.

People were not always informed about what staff planned to do or given information to enable them to make a choice. For example, we saw a staff member pulling a blanket off of a person and beginning to wheel their chair out of the room without fully explaining what they were doing. Once taken to the toilet, the blanket was put back over the person, but no further interaction was made. They were not for example, offered a drink or asked if they were comfortable etc. At lunch time we saw limited interaction from a care staff member providing individual support. They only asked if person liked what they were eating when they started to push their head away after a few mouthfuls. We also saw limited interactions from staff when afternoon tea was being served.

People were not always communicated with in a way that would promote their involvement or understanding. A relative described how a person had fallen when they had been woken suddenly by a staff member and walked to their room. The person had not been given sufficient time to become fully awake before being mobilised. A member of care staff was seen shutting a window in the lounge without asking the people sat next to it if they minded. We observed a person being moved into the home from a garden area. There was a jolt as they were pushed over a low threshold. The care staff member did not warn the person about the coming bump or apologise afterwards.

Staff did not always address people with their preferred or given name. Using a person's name helps people living with dementia to know that they are being spoken with. Instead we heard staff using general terms including "Would you like a drink darling" and "This way my love". We also observed interactions where care

staff did not ensure they were in an appropriate position that people could be fully aware of their presence when speaking with them. We saw a staff member asked several questions in rapid succession to a person. The care staff member did not allow the person time to process the information or fully engage with them and the person did not respond to the questions. We subsequently spoke with the person and by standing in front of them, speaking in short sentences and allowing time to process information the person was able to respond.

People's dignity was not always protected. A visitor told us about an occasion when they noted a brown stain on the bottom sheet of a bed a person was lying in which had not been changed following personal care.

People were not always addressed as or treated as adults. We heard a senior staff member describe an activity area as the "Boy's shed". On two occasions a senior staff member was observed greeting two men who lived at the home by saying "Hello young man." Although this was intended as a friendly greeting it would be more appropriate to use the person's name. On another occasion we heard a staff member who was assisting a person from another person's bedroom say "I can see we will need to keep an eye on you young lady". In some bedrooms we saw continence pads were stored within sight such as on the top of wardrobes. A nurse confirmed this should not have occurred and these should be stored out of sight to protect the person's dignity.

Staff did not always intervene when people were verbally aggressive to each other. For example, we saw in one area at lunch time that a man who was sat alone was singing loudly. Another person shouted "I hope it chokes you". No staff intervened and eventually the man stopped singing. In another area we saw a person standing nearby a person who was seated. One person said "Don't you bloody hit me." The other person said "I will if I want to." Staff were in this area however they did not intervene. Other people were also in this area and may have felt threatened by the interaction between the two people.

A visitor said of staff "Some are good, some are not." Another relative told us staff were "Very caring, wonderful, and excellent." Whilst a third felt staff were very good especially when their relative was not easy to care for, although they also identified that with more mental and physical stimulation the person may be less complex for staff to support.

The failure to ensure people are treated with dignity and respect at all times was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although the majority of staff interaction with people was poor we saw some positive interactions. For example we saw staff asking people if they could move furnishings before disturbing people. A care staff member asked a person who had been moved in a wheelchair, "Do you want your feet down?" The care staff member put the brakes on and moved the footrests out of the way, so the person could rest their feet on the floor. We also observed one person who was living with dementia stopping the maintenance man in the corridor to talk about something which appeared concerning to them. The person's sentences were incoherent and not relevant to any particular subject, however the maintenance man listened intently and spoke in a compassionate manner, saying "That's OK – we will figure it out." Relatives also identified some staff who they felt were very caring. For example one relative told us about a staff member saying "He's so good with the residents, he talks with them, he works so hard."

We saw a person was walking with a care staff member to the toilet. He tried to undress outside the toilet. The care staff member was directive and assertive telling the person to come into the toilet. Their prompt actions protected the person's dignity and was an example of positive care. Staff told us about the steps

they would take to ensure they protect someone's privacy and dignity. One staff member said "If I do personal care, I will make sure the door is shut and put a towel over the areas that I'm not washing." Another staff member said, "I always tell them [people] exactly what I'm doing. I shut the door and make sure the curtains are pulled." This showed that staff considered the issue of dignity when providing personal care but were not always viewing this in a larger context within the way people were treated on an ongoing basis.

A relative told us "[person's name] has a bath or shower every Wednesday if he is not too agitated. If he is agitated the carers leave it until the next day." This showed that care staff would be mindful of people's differing needs when deciding how care would be provided. At lunch time some people were shown both choices and were enabled to select the meal they wanted. The manager was aware of when it would be appropriate to use an advocate for someone, and who to contact in order to arrange this. They told us that where this was needed, they would also work closely with the person's care manager.

Visitors confirmed they were able to visit at any time and were kept informed about any changes in their relative's needs. They confirmed they were usually offered refreshments but could also help themselves from a coffee machine in the entrance area. We were informed well behaved pets were also able to visit.

People's cultural and diversity needs were considered during pre-admission assessments and care plans detailed any spiritual beliefs or needs a person may have. The manager was aware of how to access religious leaders of various faiths if required. Staff received equality and diversity training as part of their induction, where they learnt about the nine protected characteristic and shared experiences of scenarios which they may face, relating to the subject of equality and diversity. The activities coordinator said "There are church services, monthly, in the Library. One lady goes to Easter and Christmas church services if someone is available to take her."

Confidential information was maintained securely with access limited to those who had need to view this information.

Requires Improvement

Is the service responsive?

Our findings

People did not receive good person centred care and support. Assessments of people's needs were completed by the manager, before people moved to the home. This followed the providers document and when fully completed would provide comprehensive information from which a plan of care could be devised. This information was then used to develop a care plan in consultation with the person and their relatives, where appropriate. Although the care plans were comprehensive, we found some contained conflicting or duplicated information making them difficult for staff to navigate. This conflicting information had not been identified during care plan reviews which we saw were occurring monthly.

Care plan templates were not always completed fully or kept up to date with changes in people's needs. A tool used to assess staffing levels based on individual people's dependency needs was not completed in all care plans viewed other than adding the person's name to the document. Recording of people's needs and abilities was inconsistent and conflicting. For example, in one person's care plan, some parts stated the person 'has full mobility – so does not need repositioning', however on one of the recording tools for the person's care and support, there was clear evidence that care staff were assisting to reposition the person. Another example identified that one part of a person's care plan stated they 'cannot walk / immobile', whilst another part recorded the person 'can walk with a frame'. One person's care plan stated they should have four walks a day but care staff told us the person was no longer able to walk and they used moving and handling equipment to move the person. There was no updated information within the person's care plan as to how their pressure risks were managed since the decrease in their mobility. Care staff working in the area the person was living in were unable to explain how the person's risk of developing a pressure related injury were now being managed. The care plan also contained inconsistent information as to how the person's continence needs were being met stating in one part staff should support the person to the toilet and in another that all toileting needs should be met whilst the person was on the bed. Further in the care plan we saw that the person now had a urinary catheter in place. A person's relative informed us the person should be having twice daily knee massages but there was no information about this in their care plan.

We viewed the care plan for another person and saw they had lost 1.6Kg weight in the previous month. We showed the care plan to the manager and they were unable to establish the action taken following the weight loss. We were not assured that people's needs were being responded to. The manager agreed there was no easy trail within care plans to demonstrate this.

Care plans did not always contain sufficient detail to inform care staff as to how individual people should be supported. In one care file we read that if the person tried to stand unaided staff should gently maintain them in a seated position. There was no information as to how staff should do this. We asked the manager about this and they could not explain what was intended by the statement or how staff were expected to gently maintain the person in a seated position.

Staff caring for people did not always have sufficient information in order to ensure their needs were safely met. A permanent care staff member who was providing individual support for a person said "Don't ask me anything about him, I don't normally do him, I don't know." We spoke with other care staff working in the

part of the home and they were also unaware of some information in people's care plans and how their specific needs should be met. An agency staff member also told us they did not always have enough information before commencing to provide care. We saw a family member had raised the issue of staff not always knowing people's care needs in review meeting held in April 2018. These examples show that staff were not always aware of people's individual needs which is a situation which may have been continuing for a period of time.

Prior to the inspection we received an action plan from the provider's regional director. This stated that they were in the process of reviewing all care plans and that 42 had been reviewed. However we found inconsistencies and incomplete information in all care plans we viewed. This indicated that the review of care plans had not been comprehensive. We did see some individual detail within some care files viewed such as the support a person needed to maintain their personal hygiene.

As people approached the end of their lives we could not be assured that they would receive all the care they required in an individual and holistic way. At the time of the inspection we were told nobody was receiving end of life care. This indicated that the service did not realise that end of life care was not just about a person's final few hours or days but that this was a normal process which everyone living at the home would encounter. Good end of life care relies on staff having information about the person's wishes and hopes and ensuring that these are considered as part of care planning. We viewed the care plan and records relating to care provided for a person who had recently received care at the end of their life. We found there was very limited information about their individual wishes other than a note that they wanted to be cremated and a change of address for their funeral plan. There was no information about support for the person's family and any wishes the person may have had such as music/tv they may have enjoyed listening to. There was also no information about any spiritual wishes such as if they would have liked a priest or other religious leader to provide comfort or prayers. There was no care plan about hopes and concerns and the cultural, spiritual and social values planning gave an outcome to support the person in maintaining social interests and hobbies. This said they liked football but contained no information about specific teams or how staff should meet this need as the end of their life approached.

Within other care plans viewed we saw similar issues with limited information about people's preferences for the end of their life with others only stating the relative to contact and a name of preferred funeral directors. Following identifying this to the manager they contacted the nearby hospice and arranged to visit them to look at how the hospice sought people's individual views and wishes and incorporated these into end of life care plans.

The failure to ensure people received person centred care and support is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received varied feedback about activities for people. A visitor felt there should be more mental and physical stimulation for people. They said "[Person's name] does not do any activities. It is not stimulating enough and he is not invited to attend activities." A person was more positive about the activities provided and said, "I have enough to do; the daily paper, books, magazines and the television."

The service had dedicated staff employed to facilitate daily activities for all people living at Vecta House. The service had an 'Activities Evaluation Plan' in place, which documented all activities that had taken place during the year, and a scoring tool to determine the impact they had on the people involved. The tool assessed the impact each activity had on people's mood, communication and physical activity. The manager told us this was then used to establish which activities had the most success and popularity amongst people, and would be run again. During the inspection, we observed a number of activities taking

place, such as one to one activities, watching films, chair exercises, singing and a visit from Shetland ponies. The 'Activities Evaluation Plan' showed other sessions had taken place which included: Aromatherapy, arts and crafts, gardening, puzzles and games, flower arranging, planting herbs and cooking sessions. Activities staff had decorated the home for the Royal wedding with flags and banners and we were informed there would be a tea party to celebrate the occasion.

People were involved in some decisions about the home. The service was in the process of obtaining an interactive light game, developed specifically for people living with dementia. The manager told us that in order to consider purchasing this, a demonstration of the game had taken place with some of the people living at the service, who all reacted positively to the piece of equipment.

The manager had recently held a relatives meeting and planned to continue facilitating these every two months as requested by the family members involved. A survey was sent to all relatives twice a year, to gain feedback of the service overall. The manager said "I'm very open, I love getting feedback and suggestions on how to improve the home."

A visitor said, "If I needed to complain I would talk to whoever is in charge." Whilst a person said they would "ask a nurse" if they had any complaints. There was a complaints procedure in place and relatives told us they felt able to raise concerns. We viewed records of recent complaints. These had been investigated thoroughly and responded to promptly, in accordance with the provider's policy. The manager described how they would use complaints to help identify learning and to improve the service. Information about how to complain was provided in the front entrance hall however this was not immediately obvious. Visitors were also able to raise issues anonymously if they preferred. There was a suggestions/comments box in the front entrance where visitors could place comments should they wish to do so.

Inadequate

Is the service well-led?

Our findings

At our last inspection, in April 2017, we identified a breach of Regulation17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person had failed to operate effective systems and processes to assess and monitor the quality of service and to ensure regulations were complied with. At this inspection we found the service remained in breach of this regulation.

When we last inspected the home in April 2017 we identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe care and treatment, good governance and safeguarding service users from abuse and improper treatment. At this comprehensive inspection we found eight breaches of regulations and all three regulatory breaches from the last comprehensive inspection in April 2017 were repeated. There had been a deterioration in the quality and safety of the service. This demonstrated a failure of the provider to ensure that there had been effective oversight of the service since the last comprehensive inspection.

At the end of the first day of the inspection we provided verbal and written feedback to the manager and provider's area manager of the significant safety concerns we had found. When we returned on the second day of the inspection action had been taken to address these areas. Fire exits were no longer blocked or incorrectly signed, risks to some people of choking had been reduced and dangerous moving and handling procedures had been addressed with the staff concerned.

During the second day of the inspection on 18 May 2018 we requested the manager to forward us a range of documents relating to the management of the service and quality assurance audits. These were again requested on 23 May 2018 and the manager said this was being sent. These were subsequently received at 5.30 pm on 25 May 2018. These showed areas where improvement had been identified as being required on previous provider audits and reflected our findings during this inspection showing action had been taken to address these. Prior to the inspection the provider was aware that there was a need to provide additional support for the home and had arranged for a senior clinical specialist to be based at the service. However, this had not mitigated the issues we found.

Although some quality monitoring procedures were being undertaken by the manager these had not identified the level of concern we found. The manager stated they undertook three daily walks around the home which we saw occurring throughout the inspection. They stated that when these identified areas requiring improvement they would address these immediately with the staff concerned. The provider required manager's to undertake spot checks of the home including at night. The manager said they had completed one such unannounced visit since their employment commenced approximately six weeks prior to the inspection. They informed us this had not identified any concerns. The provider's procedures also included randomly selected room documents being scanned and sent to the area manager for review. However, this had not identified the inconsistencies and conflicting information we found in records we viewed.

Policies and procedures were supplied by the provider and were updated yearly or when changes were

required. Staff had access to these via the provider's internal computer system with policies also available in paper format within nurse's stations around the home. We saw these were available for staff and ensured that staff had access to appropriate and up to date information about how the service should be run however staff had not always been following the provider's policies as identified in previous sections of the report.

The quality assurance systems and processes undertaken by the manager and provider had not ensured that people were receiving a service which always met their needs and mitigated the risks relating to the health, safety and welfare of people and others who may be at risk in the service. The provider's area manager told us they had been undertaking more frequent monitoring of the service and provided additional support from within the company as they were aware that the service required improvement. However the quality assurance systems used had been ineffective in implementing and sustaining improvement within a reasonable timescale. There were widespread and systemic failings identified during the inspection which are detailed throughout this report. Failings included shortfalls relating to treating people with respect and dignity, medicines, infection control, risk assessments, care planning and consent.

Records relating to the management of the service had not been effectively reviewed and assessed; we found omissions and discrepancies that had not been identified by the manager's and provider's quality assurance systems. For example, care plan audits had failed to identify conflicting information relating to people's mobility needs.

The failure to provide good governance to ensure the safety and quality of service provision is a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection we asked the provider for an action plan in relation to the risks to people and concerns we identified during the inspection. We also asked them to review their admission strategy for the same reasons. The provider submitted an action plan within the required timescales and undertook to provide additional monitoring and support for the service. They also undertook not to admit new people to the service until they were confident people were safe and would receive the care they required.

All services registered with the CQC must notify us about certain changes, events and incidents affecting their service for the people who use it. Notifications tell us about significant events that happen in the service. We use this information to monitor the service and to check how events have been handled. The service had not notified CQC about all incidents and events as required.

Prior to the inspection we received a Provider Information Return (PIR) (April 2018). 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. This noted that there had been a police incident; we were not notified of this as is required. The PIR also told us there had been five medicine errors in the previous 12 months. The manager was unable to tell us about these meaning we could not review the records and determine if these should have been notified to us. The manager stated they would investigate these and provide us with further information but this has not been received. We also found a further serious injury to a person that had required reporting which the service had failed to notify.

The failure to ensure that statutory notifications were made as required was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The service did not have a registered manager. The previous registered manager had left the service in March 2018. A new manager had been appointed and had been in post for six weeks at the time of this

inspection. They informed us they had commenced the process to register with the commission and would be submitting their application in due course. Staff were positive about the new manager. One staff member said "The morale has been low…I can see major changes since [manager] has been here." Another said "It's been hard, but we needed a change. I feel [manager] will be good for this home. I've come back to being happy." The manager was receiving support from members of the provider's senior team including an area manager, health and safety lead and a clinical advisor who had been based at the home. The manager felt they received a lot of support from the provider and had been linked with an experienced manager of another home who was providing support on a formal and informal basis.

The manager identified their goals and values as being "Vecta House is an important provider and I want it to be high quality with person centred care and a focus on communication to allow people to live a happy and fulfilled life." They identified that they would achieve this by setting realistic goals and were aware that this would take time as there was a need to change the services culture and welcome innovation into the home. The new manager had introduced weekly senior staff meetings which focused on positives to build staff confidence and was working alongside all staff to help build trust. Daily meetings with senior staff on duty were also occurring to help ensure all staff were aware of any significant events in the home.

A person said "I like it here because of the nice fresh air and lovely flowers". Another person said "I love it here and would not be anywhere else". However, a family member told us about delays in arranging for electrical equipment to be tested to ensure it was safe and could be used in the home. They explained how they had brought a radio and fan for their relative to make their bedroom a nicer place for the person to spend their time however after ten days these still could not be used.

Staff were also positive about the home and told us "Everyone's lovely, it's great, I love it." Another staff member said "The people are lovely and so friendly." All staff told us that they would recommend working at Vecta House, one staff member said "Oh yes, I've already referred loads of people who now work here!"

Providers are required by law to follow a duty of candour. This means that following an unexpected or unintended incident that occurred in respect of a person, the registered person must provide an explanation and an apology to the person or their representative, both verbally and in writing. The manager understood their responsibilities in respect of this. Family members were also kept informed verbally of minor incidents and changes in their relative's health.

Providers are required to display the ratings from inspections so that people, relatives and visitors are aware of these. The rating from the previous inspection, undertaken in April 2017, was appropriately displayed at the home and on the provider's website.

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 18 Registration Regulations 2009 Notifications of other incidents
Treatment of disease, disorder or injury	The failure to ensure that statutory notifications were made as required was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The enforcement action we took:

We have imposed a condition on the provider that they must send us an action plan each month.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The failure to ensure people received person centred care, support and care planning is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We have imposed a condition on the provider that they must send us an action plan each month.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	The failure to ensure people are treated with dignity and respect at all times was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We have imposed a condition on the provider that they must send us an action plan each month.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The failure to ensure that, where people lacked the capacity to give informed consent, action was

taken to comply with the Mental Capacity Act when providing care was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We have imposed a condition on the provider that they must send us an action plan each month.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The failures to ensure the proper and safe management of medicines, appropriate infection prevention and to ensure risks relating to the safety and welfare of people using the service were assessed and managed were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We have imposed a condition on the provider that they must send us an action plan each month.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The failure to provide good governance to ensure the safety and quality of service provision is a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We have imposed a condition on the provider that they must send us an action plan each month.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed
Treatment of disease, disorder or injury	The failures to ensure that all necessary recruitment checks were undertaken was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We have imposed a condition on the provider that they must send us an action plan each month.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The failure to ensure that there were enough

Treatment of disease, disorder or injury	suitably skilled staff to meet people's needs was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We have imposed a condition on the provider that they must send us an action plan each month.