Care Quality Commission

Vicarage Nursing Home Limited

The Vicarage Nursing Home

Inspection report

The Common
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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

This inspection took place on 8 and 9 December 2014 and was unannounced. At our previous inspection no improvements were identified as needed.

The Vicarage Nursing Home provides accommodation with personal and nursing care for up to 52 people living with dementia. At the time of our inspection 46 people were living at the home.

The home had a registered manager post who was present for our inspection. 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.

People's rights were not being protected when they could not consent to their own care or make their own

Summary of findings

decisions about their own care. When consent had been given by relatives there were no records to say why the person could not make their own decision and why decisions made for them were in their best interests.

We have made a recommendation about the provider seeking guidance on dementia care environments.

Staff had identified and understood the risks associated with people's care. These included where people were at risk of falls, not eating or drinking enough or problems with their skin. We found that although staff were aware of these risks people's care records did not always reflect actions staff were taking to reduce the risks.

Training that staff received was not always effective in safely meeting people's needs. Not all staff had received training that would help them to support and understand people living with dementia.

People had been assessed as to whether they were at risk of not eating and drinking enough. Although these risks were monitored there was not always clear information in their care records as to how this was being done. People had access to healthcare when they needed it.

People were not always actively involved and supported to express their choices or views about their care and treatment. The way that staff spoke with people was not always understood and was sometimes disrespectful to them. People were frequently addressed as love, sweetheart, good man and good girl.

Staff had a good knowledge of the people who lived at the home and were able to tell us how people liked to be supported and what their likes and dislikes were. We could not confirm these were accurate as this information was not in people's care records.

Visitors were made welcome and were able to visit at any time. There were areas of the home where visitors could have privacy with their family members and this was respected by staff. Relatives felt involved in and kept up to date about their family member's care.

The provider sought the opinions of relatives and staff and used this to help improve the home. Relatives' meetings were held regularly and concerns raised were dealt with. Staff felt supported in their roles and felt confident to report any concerns they had to the management.

Quality assurance processes had identified some areas for improvement and action was in progress to address these. However, we did find some issues during our inspection which the provider and registered manager had not identified.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe.

Although risks to people had been identified there were not always plans in place to instruct staff how to reduce these risks. We also saw that some staff placed people at risk of harm due to poor moving and handling techniques.

Requires Improvement

Is the service effective?
The service was not consistently effective.

People's rights were not always protected. This was because the provider did not support people or those acting on their behalf to consent to or make decisions about their care. Not all staff were trained to support people who lived with dementia and were not aware of how to ensure people's rights were protected.

Requires Improvement

Is the service caring?
The service was not consistently caring.

Staff did not always involve people in making decisions or give them choices about their care. Communication with people was not always respectful or effective.

Requires Improvement

Is the service responsive?
The service was not consistently responsive.

The environment was not consistent with best practice in dementia care. Staff knew what people's preferences, wishes and interests were but this information was not always contained within their care plans. The provider sought and listened to the opinions of relatives to help improve people's experiences.

Requires Improvement

Is the service well-led?
The service was not consistently well- led

Regular checks were completed on the quality of care to help drive improvements. The registered manager had identified some areas that needed improving and had started to address these. However, we found issues during our inspection that the provider's quality assurance processes had not identified. Therefore we could not be assured the processes in place to monitor the service were effective.

Requires Improvement

The Vicarage Nursing Home

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 8 and 9 December 2014 and was unannounced.

The inspection team consisted of two inspectors and specialist advisor. A specialist advisor is a person who has specialist knowledge in a specific area. The specialist advisor who accompanied us was a specialist in nursing and dementia care.

Before our inspection we spoke with the local authority (LA), clinical commissioning group (CCG) and Shropshire Healthwatch. Concerns had been raised about how the home was monitoring people where they had been assessed as at risk following a number of safeguarding referrals. We also looked at our own system to see if we had received any concerns or compliments about the home. We analysed information on statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required to send us by law. We used this information to help us plan our inspection of the home.

On the day of our visit we spoke with four relatives, the registered manager, deputy manager, operations manager and 11 staff. We reviewed nine records which related to consent, people's medicines, assessment of risk and people's needs. We also reviewed other records which related to staff training, recruitment and the management of the home.

During our inspection we used the Short Observational Framework for Inspection (SOFI) observation. SOFI is a way of observing care to help us understand the experience of people who live at the home. We used this because people living at The Vicarage Nursing Home were not able to tell us in detail what it was like to live there. We also used it to record and analyse how people spent their time and how effective staff interactions were with people.

Requires Improvement

Is the service safe?

Our findings

Staff we spoke with were able to tell us the risks associated with people's care and how they supported people to stay safe within the home. Such as who was at risk of falls, who had reduced mobility and who was at risk of skin breakdown. Even though staff told us how they supported people we found this was not documented fully in their care records. Where risk assessments were completed we found that people's care plans did not always include a plan of care to help minimise and manage these risks. One person had been assessed as being at high risk of developing pressure ulcers. Their care plan did not contain information on how this person's skin was to be monitored or cared for. We saw one person had been assessed as being at high risk of skin breakdown. This person was sat in a wheelchair and an armchair with no pressure relieving cushion in place. One person's care plan stated that they needed hourly checks throughout the night but did not say why. When we asked to look at these checks no records were found to show these had been completed. This meant that although staff were aware of the risks to some people they had little information to inform them how to minimise these risks and safely support people.

During our inspection we saw that staff did not always use best practice when supporting people with their mobility. We saw one person being pushed in a wheelchair with no foot plates attached. We saw one person being moved a short distance while they were in their armchair. This allowed their feet to drag on the floor which could potentially cause the person harm. We saw three staff using a hoist to move a person from a wheelchair to an arm chair. Although we observed the person was safe the staff member who operated the hoist was talking to another staff member. This meant their full attention was not on the person or the hoist. We spoke with the manager about what we had seen. They told us they were disappointed in the staff's practice and would address this with them. We saw records which confirmed staff had received training in the safe moving and handling of people, however they did not put this training into practice.

The manager told us that staff had received training in managing behaviour that challenged. However, not all staff we spoke with were confident supporting people when incidents happened. One staff said, "You soon learn what to do if someone gets violent, you get out of the way". The manager told us that after incidents closed-circuit television (CCTV) footage was reviewed and if lessons could be learnt this was discussed with individual staff or at team meetings. They told us they had CCTV in the communal areas of the home. Access to this was password protected.

Some people received their medicine 'when required'. We saw that protocols were in place that had recently been reviewed and were awaiting approval from the provider operations manager. The deputy manager told us the use of people's 'as required medicine' had recently been reviewed by the doctor to make sure people were prescribed only for medicines they still needed. The deputy manager told us that when people refused their medicine another staff member would try again later. We saw that one person had recently had the timing of their medication changed. This had been agreed by the person's doctor. Staff who gave medicines had received training to ensure they were competent to do so and their competency to safely administer medicines had been assessed.

Medicines were stored in accordance with good practice. People's medicine administration records were complete and up to date which showed that people were receiving their medicine when they needed them. However, we found that the use of prescribed topical medicine, such as creams and ointments were not being used consistently. Charts for recording when people had their topical medicine applied did not contain clear instruction on how often they should be applied. We asked the manager how staff knew how often to apply these creams. They told us the prescription written by the doctor did not contain this information. The manager told us they had sought advice from the doctor and had made the decision themselves as to how often these were to be applied. We saw there were gaps in people's charts when staff had not applied people's topical medicine. The manager told us a review of prescriptions was taking place and they were working with the CCG regarding this.

Most relatives we spoke with did not express any concerns with their family member's safety. Staff we spoke with understood how to keep people safe and protect them from harm and abuse. They were also aware of how they could whistleblow which meant they could take any concerns they may have about poor practice to appropriate agencies outside of the home. Staff knew which people required one to one supervision and we saw

Requires Improvement

Is the service safe?

that this was carried out during our inspection. One staff member said, "It's our job to ensure people are safe here. Many of our residents do not understand what is happening and cannot look out for themselves".

On the day of our inspection we saw there were sufficient numbers of staff to support people's needs. We saw that people were not kept waiting for care and received assistance when they asked for it. The manager told us they had made a lot of staff changes and felt they now had a more stable staff group working at the home. They told us that although agency staff were used the agency mostly sent the same staff. They told us this helped to make sure that they were familiar with people's needs. On the day of our inspection three agency staff were working. One agency staff said, "The staff are really accepting of agency staff". We saw evidence that appropriate employment checks were completed on new staff. This meant the provider was following legislation and ensured staff had the required employment checks prior to starting work at the home.

Requires Improvement

Is the service effective?

Our findings

We found the requirements of the Mental Capacity Act 2005 (MCA) had not been correctly followed. People's capacity to make their own decisions had not been appropriately assessed and we found no evidence of best interest meetings. Some staff we spoke with had a basic understanding of what the MCA was but not how it affected their practice. Most staff had received training on this subject. One staff told us they had attended training recently but said, "I can't remember". Staff were not aware of who was subject to Deprivation of Liberty Safeguards (DoLS) authorisations. One staff said, "It's all too confusing. There are a few here; in fact I think most of them have (a DoLS)". The manager told us that only one person had a DoLS authorisation in place. We looked at seven people's assessments and found they had been assessed as not having capacity. These people's records had statements such as; '[person's name] lacks capacity to make specific decisions. On some occasions decisions will have to be made in [person's name] best interest'. However the records contained no information on what decisions were to be made on their behalf. We also saw that no best interests meetings had been held. Best interest meetings are a requirement of the MCA and identify what decisions are to be made on a person's behalf and why the decision is in their best interests. Because staff and the manager did not have a clear understanding of the requirements of the MCA there was a risk people's rights would not be supported as required by the law.

We found no evidence that people had consented to their own care and treatment. We saw some people had a 'consent to photography form' which had been signed by their relatives. However, there were no records of why relatives had signed these forms on the person's behalf. We also saw no records to indicate that people or relatives acting on their behalf had consented to having bed rails in place.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us they and staff had received training in August 2014 for MCA and DoLS. However, we found that the first DoLS application had not been made until November 2014 although this person already lived at the home with restrictions in place. The manager told us they had only started to think about DoLS after their training in August 2014. Although the manager was aware of her responsibility under DoLS she had not sought the appropriate authorisations in a timely manner. The manager told us one person had a DoLS authorisation in place. She had applied for two more DoLS applications which were waiting for authorisation from the local authority.

Some staff we spoke with told us they had not received any training in supporting people who were living with dementia. We found that this affected their understanding of how to support people effectively. We asked one staff member if they had received any guidance on how to support people with dementia. They said, "No, I was told during my induction to talk slowly and clearly". The manager told us that dementia awareness training for all staff was booked in the near future. Most staff we spoke with told us they felt supported in their roles and they felt their training was good. They told us that they received regular support from the manager and deputy managers to help them in their work. However, we found that staff training was not always effective. This was because we had observed poor practice with moving and handling and were not assured that all staff understood MCA and DoLS. We spoke with the manager about this who assured us they would look into further training.

We saw that some relatives came in at lunchtime to support their family members with their meal and spend time with them. One relative said, "I can tell you the carers here are brilliant, we can't fault them". People were offered a choice of what they wanted for their meal and staff provided assistance when it was needed. Throughout our inspection we saw most people were offered a choice of drinks and snacks by staff.

We saw that people had been assessed as to whether they were at risk of not eating or drinking enough. One person had been assessed as at risk and we found there was not clear information in their care plan as to how this was being monitored. We found that some care records were not up to date with regards to recording their food and drink. However, we did not find this had an impact on people who used the service and the manager was able to talk to us about the actions they took to manage this.

Requires Improvement

Is the service effective?

On the second day of our inspection we saw the local doctor was conducting a surgery at the home. We saw that people had access to other healthcare professionals including doctors, opticians and chiropodists when they needed it. We saw that a tissue viability nurse had been involved for a person who had a pressure ulcer and had attended the home regularly to monitor this person. Staff told us they received information about any changes in a person's health at the start of each shift.

Requires Improvement

Is the service caring?

Our findings

Staff did not always involve people in making decisions or asking for their views. Whilst we were speaking with a person in their room a staff member walked in and said, "Let's go to the lounge then". This person's television was switched off and they were taken in their wheelchair to the lounge. There was no discussion with this person if going to the lounge was their choice. However, another person in their room was asked by a staff member if they wanted help with their wash or should they come back later. They listened to what the person wanted and respected their choice.

We asked a staff member how they supported people to make choices about their care when they could not communicate their views. One staff member said, "It's a guess but it's an educated guess as we have been able to ask some of them in the past or we have talked to their visitors". We found where people could not communicate their wishes or be actively involved in making decisions about their care, there was little evidence of how staff supported them. We saw no alternate methods of communication used to allow people with dementia to be involved in their own care. We saw that some people were not offered choices of what drink they would like. When we spoke with staff about this one staff member said, "We get to know the residents very well and know what they want". Staff we spoke with knew the people they supported and told us they would talk with relatives to find out information about them.

We heard staff speaking to people using terms which could be seen as disrespectful such as love, sweetheart, good man and good girl. We saw that staff did not always communicate effectively with people and did not always focus on people when they wanted to talk. We saw one staff walk into a lounge and ask, "Whose hands need wiping?". No person sat in the lounge answered them. Whilst they were moving around the lounge wiping people's hands one person was trying to start a conversation but the staff member continued what they were doing. However, we did see some good interaction. We heard some staff re word sentences so people could understand what they had said. We saw all staff treating people in a caring way and compassionate way when they supported them. One staff member said, "Each person is an individual and needs slightly different things from us".

One relative we spoke with said, "Yes, [person's name] dignity is respected. We are given privacy if we want it when we visit". They told us they could visit their family member at any time and were always welcomed by staff. We saw the large lounge area had been divided into smaller areas with the use of furniture which helped to create several quieter and private areas for people and visitors. Staff we spoke with understood and could tell us how they respected people's privacy and dignity. We saw that staff knocked on people's bedroom doors and asked to enter.

Requires Improvement

Is the service responsive?

Our findings

One relative told us they contributed to planning their family member's care. They told us they were kept informed of their family member's care and felt up to date with what was happening with them. Staff we spoke with were able to tell us what people's preferences and wishes were but we could not confirm these were accurate as this information was not in people's care records. Staff we spoke with were aware of people's needs and told us they knew this information from daily shift handovers and supporting people rather than people's care plans.

People's care plans were held on a computer system which not all staff had access to. Some staff told us they had not received training for the computer records so did not use them. One staff member said, "I've never been trained so I won't use it (the computer system)". One agency staff told us they had no access to the computer and so were unable to see people's full care plans. The manager told us and we saw that people had 'mini care plans' in their rooms which staff had access to. These were designed to give staff an overview of people's needs and how to support them. The manager acknowledged people's care plans were not personalised and did not contain information on their preferences or wishes. They told us the activities co-ordinator was creating a 'life history' document for every person. They were speaking with every person and their relatives to get details of their interests, past jobs, routines, preferences. We saw some of these documents where the information had been completed. The manager told us these documents had already been printed and were waiting to be put into people's rooms.

On the day of our inspection we saw little social interaction for some people. An activities co-ordinator was employed full time at the home but on the first day of our inspection they were not working at the home. Staff told us, "We try to do things that people enjoy. The activities co-ordinator works hard to make things happen but they are only one person and we don't have time to do much with people". In the afternoon we saw some people participate in singing in one of the lounges. We were told by staff that events were organised within and outside the home and that people and relatives were encouraged to participate in these. We spoke with staff about how they provided individual activities for people with dementia with regards to promoting memories or reminiscence activities. Staff told us when possible they would sit and talk with people about their lives or family. One staff member told us some people used to enjoy football and going to matches. They said, "We have to pick our time to do this but some of the men love to kick a football". We heard one staff member talking with one person about football. We found that the environment was not entirely dementia friendly. We saw some signage in the communal areas indicating where the toilets were. However, we saw the corridors which led to bedrooms had no directional signage on them. Lighting was low in the lounge and dining areas and floor coverings were different colours. These could have a negative effect and increase the risk of falls for people living with dementia.

We looked at how the provider sought people's and relative's opinions on the service. We saw a book in the home's foyer where visitors were invited to make comments, compliments and raise any concerns. This was checked regularly by the manager and appropriate action taken if needed. The manager told us they had received four complaints in the last 12 months. We saw records of how the complaints had been dealt with and the outcomes from each. The manager told us that visitors were encouraged to report issues. Relatives' meetings had been held every two to three months in 2014 and surveys had been sent to relatives and staff in July 2014. These were to gain opinions and feedback on the home. The results from the surveys had been fed back to relatives in a written report.

We recommend that the service considers the Alzheimer's Society guidance on dementia care environments and the Social Care Institute for Excellence Dementia Gateway.

Requires Improvement

Is the service well-led?

Our findings

The manager told us there was an on-going issue with some staff not accurately recording information on people's daily records, such as food and fluid intake. The manager told us this was an on-going issue and they had recently introduced a new system where all daily records had to be checked by the nurse in charge. However on the day of our inspection we saw gaps in people's daily records from earlier in the week. The manager told us they were going to review this after the first four weeks of using the new system to determine its effectiveness.

The manager was aware of some improvements that needed to be made within the home and told us the feedback we gave her after our inspection was not unexpected. Regular audits were completed by the manager and the provider's operations manager. Audits included care plans, medicines, quality of food, infection control, staff training and equipment. We saw an audit completed in September 2014. The manager had identified that care plans were not personalised at this audit. They told us they had allocated new responsibilities to nursing staff to update care plans and the activities co-ordinator had been gathering information on people's preferences. This work was still on going. The manager told us she recognised that some training still needed to be completed by staff and had prioritised training in dementia care. She also recognised the home's environment needed improving to make sure it was more appropriate to people living with dementia. However, the manager had not identified that people's consent to their care was not recorded or that the MCA process had not been correctly followed. The manager told us that one of her key concerns was over MCA assessments and DoLS authorisations.

The manager told us the provider was kept up to date on events within the home. The manager told us they sent a weekly report to the provider which included information on accidents, incidents and any concerns. The provider's operations and general manager visited the home regularly to complete their own audits which they feed back to the provider. All managers attended a monthly governance meeting. The manager told us she was supported by the provider and other managers in making improvements to the home. We found that the manager had not notified us of the DoLS authorisation that was in place. She told us she did not know we had to be informed. Since our inspection this has been submitted to us.

Staff we spoke with told us the culture of the home was to create a caring environment. One staff said, "Staff really care here". This was echoed by the manager and deputy manager. Staff were positive about the support they received from managers at all levels. One staff member said, "Matron [registered manager] is always available to be contacted and so is the deputy". The manager told us that there was an on call rota for themselves and the deputy manager. This meant that staff had access to management when they needed it.

One relative had written a comment which said, "The meetings with [activities co-ordinator's name] and relatives are excellent. It is an opportunity to voice disquiets and dispel doubts". The manager told us feedback from relatives' meetings and surveys was used to help develop the service the home provided. The manager and activities co-ordinator told us that issues raised at meetings were addressed and responded to. The manager did not attend these meetings and told us they felt relatives would feel more comfortable without managers present. In response to concerns raised at one meeting the manager had attended the next meeting. Some relatives had thought the manager was unapproachable because she was always in the office. In response to this the manager had spoken with relatives about her role and given them an update on recruitment, responsibilities of staff and her responsibilities within the home. The activities co-ordinator told us that since this meeting relatives now understood the manager's role better.

Staff told us they felt confident in raising concerns with the manager and they were encouraged to question practice. They told us information on the home was shared during regular team meetings. An overview of safeguarding processes had been shared with staff at these meetings to ensure they were aware following recent concerns raised by the CCG. This information had also been shared with some relatives.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered persons did not have suitable arrangements in place for obtaining consent. The requirements of the Mental capacity Act 2005 were not being met. Regulation 18.