Clarkson House Residential Care Home Ltd

# The Vicarage Residential Care Home

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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|---|---|
| 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

The Vicarage is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The Vicarage is a large Victorian property that has been extended and adapted into a care home for older people. Bedrooms are located on the ground and first floor, storage and laundry facilities are in the basement. There is one lounge and two dining rooms. The Vicarage is registered to provide accommodation for up to 30 older people and is situated in the Audenshaw area of Tameside.

At the time of our inspection there were 23 people living at The Vicarage.

This inspection was carried out over two days between 22 and 23 January 2019. Our initial visit on 22 January 2019 was unannounced.

We last inspected The Vicarage in May 2018. At that inspection we rated the service as inadequate in all domains; safe, effective, caring, responsive and well-led. The overall rating for the service was inadequate and the service was placed in special measures. At that inspection we found regulatory breaches of six Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to a lack of person-centred care, poor infection control, keeping people safe, staff numbers, medicines, dignity and respect, safety of the building and equipment, incorrect diets, complaints, staff training and induction and inadequate governance of the home. Three of these breaches of regulations were repeated breaches from the previous inspection of January 2017; the safe management of premises and equipment, staff training and induction, and ineffective governance of the service.

At the last inspection in May 2018, we also identified three breaches of the Care Quality Commission (Registration) Regulations 2009. These were a failure to notify us of death of service users and other incidents at the home and a failure to display previous inspection ratings.

The service had a registered manager in place. 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.

At this inspection we found improvements had been made in some areas of the service. However, we identified repeated breaches of four regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches related to keeping people safe from harm, staff training/levels, dignity and respect and governance of the home. Three of these breaches had been identified in the inspection of January 2017. This meant that we had identified three breaches of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014 on three consecutive inspections. At this inspection we also identified one further breach of the regulations relating to consent.

We also identified two repeated breaches of the Care Quality Commission (Registration) Regulations 2009. These were a failure to notify us of death of service users and other incidents at the home.

We made one recommendation relating to ensuring conditions of Deprivation of Liberty Safeguards (DoLS) were being met.

Since the last inspection the service had been supported by the local authority's Quality Improvement Team (QIT) and they had made progress in some areas of the service. These included the implementation of new policies and procedures, cleanliness and décor of communal areas, making the environment more dementia friendly, the employment of a deputy manager, improved infection control practice, building safety checks and documentation relating to people's care needs. However, we found the registered manager had only recently started to engage with this support and the service had not made enough progress in relation to the safety of people living at home or their experience of living at the home.

As a result of the last inspection's findings the local authority suspended placements at the home.

Accidents and incidents were recorded and counted; however, no action had been taken to analyse trends or mitigate further risk to people.

The home did not provide person-centred care and people were not involved in planning their care. People did not have keys to their rooms and a 'bathing schedule' was in place.

We found the communal areas of the home to be clean and free from odour. However, some people's bedrooms were unclean and had an offensive odour. On visiting some people's rooms we found instances where bedding was unclean, old and of poor quality.

We saw some caring interactions between people and staff; however, we also saw instances where people were not given choice and staff did not always gain consent. People did not always look clean or well groomed.

We observed some improvement in safe moving and handling techniques when assisting people. However, we also saw one instance where a person was not assisted safely.

We saw that supervisions for staff had been introduced since the last inspection alongside the introduction of a matrix to give managerial oversight of staff training; however, we found staff had not consistently received all the training they required.

No staff had received first aid training and there were no adequate first aid kits on site. We requested this be remedied as a priority during the inspection.

A tracker procedure had been introduced to monitor people who were subject to Deprivation of Liberty Safeguards (DoLS).

People's consent to care had not always been obtained and decisions had been made about their care without their, or a representative's, involvement.

People's day consisted of sitting in the lounge and everyone being moved to the dining room for meals. People did not have access to the gardens as this was not safe.

Some activities had recently been introduced at the home; however, there was no activities co-ordinator in post and care staff told us they were required to add this into their care and support duties.

People's doors had a self-closing mechanism and this may make it difficult for them to leave their room if they wished. In the rooms we visited, we found call bells did not have cords to enable people to call for assistance and we requested risk assessments were put in place during the inspection. We found everyone living at the home had a motion sensor beam in their room that alerted staff via an alarm call if they got out of bed. We did not see where people had been individually assessed as to whether this was a required safety measure.

The service had not fully complied with a Notice of Deficiencies issued by the local fire service regarding fire safety at the home.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. 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.

There were not always enough staff available to meet people's needs.

First aid provision and the management of accidents and incidents was inadequate.

Improvements had been made to care documentation.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

The registered manager had not ensured staff were adequately trained to effectively care and support the people living at the home.

Care and support was not always provided in line with the Mental Capacity Act 2005.

Communal areas had been improved to make the home more dementia friendly.

### Is the service caring?

**Requires Improvement**

The service was not always caring.

Staff were mainly kind and reassuring when interacting with people; however, staff did not always give choice or provide explanation when providing care.

People's bedrooms were tired and dated and bedding was old and in poor condition.

Feedback from people and their visitors was positive around how

caring staff were.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

People did not always take part in meaningful social stimulation and activities that met their needs.

People and their relatives were not always actively engaged in the planning or reviewing of their care

Improvements had been made to the complaints procedure.

## Is the service well-led?

**Inadequate**

The service was not well led.

Systems of governance were in the process of being implemented; however, they had not been established or operated effectively in order to assess, monitor and continually improve quality of the service.

We identified some improvements had been made at the home; however, where breaches of the regulations and concerns had previously been identified, they had not always been acted upon and remedied.

Feedback from people and visitors was positive regarding the manager.

# The Vicarage Residential Care 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 22 and 23 January 2019 and day one was unannounced. The inspection was carried out by one adult social care inspector, one inspection manager and one health and safety specialist adviser on day one. Day two was carried out by two adult social care inspectors and one 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. This person had experience of services for older people.

Before we visited the home, we checked information we held about the service including information requested from the local safeguarding team and statutory notifications received at CQC. Statutory notifications are information the provider is legally required to send us about significant events that happen within the service. We also met with the quality improvement team, who were present supporting the home on both days of our inspection, to gain their feedback on the service.

On this occasion, we had not asked the service to complete a Provider Information Return (PIR). This is a document that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the two days of inspection, we reviewed a variety of documents, policies and procedures relating to the delivery of care and the administration and management of the home and staff. This included three people's individual care records, a sample of five people's medication administration records (MAR) and three staff personnel files to check for information to demonstrate safe recruitment practices. We also

attended the morning staff handover meeting on both days of our inspection.

We walked around the home and looked in all communal areas, bathrooms, the kitchen area, store rooms, the medication room, basement and the laundry room. We also looked in several people's bedrooms.

As part of the inspection process we observed how staff interacted and supported people at mealtimes and throughout the two days of our visit in various areas of the home. We spoke with eight people who use the service and eight relatives. We also spoke with the registered manager, the deputy manager, the team leader, care staff members and one visiting professional.

Inadequate

# Is the service safe?

## Our findings

People we spoke with at The Vicarage told us they felt safe living at the home. One person told us, "There's always someone around and I'm not on my own." Visitors we spoke with were also positive regarding their relative's safety. One visitor told us, "From day one I felt mum was safer here than at home."

During our last inspection in May 2018, we found the registered provider was not meeting the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe care and treatment. Due to our findings the overall rating for this key question was rated as inadequate.

At this inspection we checked to see if improvements had been made. We found the provider had made some improvements but continued to be in breach of the regulations.

At our inspection in May 2018 we found infection control practice was inadequate and the home was not conducting their service in line with the Health and Social Care Act 2008 Code of Practice on the Prevention and Control of Infections Guidance.

We were shown the infection control audit report carried out by the CCG in October 2018 where the home had scored 78% and were given actions to complete as a result. At this inspection we found some improvements had been made. The home had introduced a new laundry system and an additional cleaner for the home. The communal areas were now clean and free from odour. However, during a tour of the home we visited eight bedrooms and found these were not always clean and three rooms had an offensive smell. At the previous inspection we identified one person's room had brown matter on their wall and crash mat. At this inspection we found another person's bedroom wall and bedding was stained with brown matter and their carpet and towel were heavily stained. We requested this room was cleaned and the bed/towel changed as soon as possible.

At our inspection in May 2018 we found the management of accidents and incidents was ineffective. People were not protected from the risk of harm when an accident had occurred and no analysis had been carried out in order to identify trends or mitigate any further risk.

We found no improvements had been made at this inspection. The registered manager was using the same system and procedures. Although accidents and incidents were counted and recorded, follow up information was not recorded, for example, what injuries the person sustained and diagnosis if they had been transported to hospital. We found two instances where someone had been taken by paramedics to hospital and there was no record of the outcome and the deputy manager and team leader were unable to tell us. We found no effective analysis was carried out and actions taken to mitigate any further risks to people and prevent further accidents was not recorded. During the inspection we identified one person who had suffered 12 falls since January 2018 and no action had been taken by the home or referrals made to other health professionals. This led us to raise a safeguarding alert with the local authority.

At the previous inspection in May 2018 we identified there was no effective observation system for monitoring people following a fall. Staff told us they completed a basic observation chart; however, the observation chart did not contain any information around the signs a person required medical assistance to guide staff. At this inspection we found a seven accident reports where a person had banged their head and it was unclear what action had been taken as a result to monitor their condition.

We also identified at the previous inspection in May 2018 that there were no risk assessments in place where people were taking certain medications. There was a high number of people living at The Vicarage who were taking anticoagulant medicines. Some people who take anticoagulant medicines are at a higher risk of internal or profuse bleeding when they have suffered an accident and plans should be in place to manage this risk. At this inspection, we found a whiteboard had been put up in the one office which highlighted those individuals taking these medicines. There was no individual, person-centred plans in place to evidence the home had addressed any potential, individual risk of taking these medicines. We saw where one person had suffered two falls, each time injuring their face. One injury led to purple bruising around their eye and another led to a wound requiring wound closure strips. This person was taking an anticoagulant medicine; however, there were no risk management plans or direction for staff regarding what action should be taken to monitor their condition. There was no evidence the person had been monitored or any medical attention sought as a result of these injuries.

At this inspection we identified that twenty six accidents had occurred at the home between June and December 2018; however, we found only three care staff members had received the home's falls awareness training. This meant that staff may not know how to safely manage someone who has suffered a fall.

The Health and Safety (First Aid) Regulations 1981 require employers to provide adequate and appropriate first aid equipment, facilities and people. An assessment of first aid needs should be carried out by the home to determine what those needs are. However, we found no assessment had been carried out, first aid equipment was inadequate and no staff had received first aid training. Therefore, there was no qualified first-aider on site at any time. Following the inspection, the provider produced evidence that staff had undergone Basic Life Support training. We spoke with the deputy manager of our immediate concerns and they arranged first aid training and ordered appropriate first aid kits to be delivered the next day.

When incidents occur where people had suffered an injury, the registered manager is required under the terms of their registration with CQC to inform us of these incidents. At the last inspection in May 2018 we found several instances where people had suffered an injury and we had not received notifications since 2016. We informed the registered manager of their obligations and our findings during that inspection. However, at this inspection we found the registered manager had failed to notify us of further incidents where people had sustained injuries. This constitutes a further failure to notify.

We identified at the last inspection that not all people had a call bell in their bedroom or the call bell cord did not reach past the middle of the bed to enable people to request assistance from their bed. We visited several bedrooms during this inspection and found none of these people had a working call bell cord in place. We reported our findings to the registered manager, who told us people were checked by night staff every two hours and a floor sensor beam was in place. This meant people may not be able to request assistance when required, for example, if they felt upset or unwell or needed to go to the bathroom, they may have to wait up to two hours for assistance. As per the last inspection there were no risk assessments in place for people who, due to their condition or disability, may not be able to use a call bell. We requested risk assessments were put in place during our first day of inspection.

We noted in two people's bedrooms that slats of wood had been placed on the floor between the bed and

the wall and each person was using an electric airflow mattress. We discussed this with the deputy manager and they told us it was to prevent the bed from touching the walls and marking the wallpaper. We reported our concerns to the registered manager as there was no risk assessment in place to assess the safety of gaps between their mattress and the walls.

Throughout the inspection in May 2018 we observed some good practice during moving and handling; however, we also observed several instances where poor practice was used and people were put at the risk of harm where we had to report staff to the registered manager. At this inspection we again mainly observed good practice when assisting people. However, we observed one incident that required us to request the registered manager send a safeguarding alert to the local authority for the incident to be reviewed. As a result, a meeting was held and the incident was logged as a concern only.

We found that people had personal emergency evacuation plans (PEEPs) in place. A PEEP provides additional information on accessibility and means of escape for people with limited mobility or understanding and includes a plan specifically designed for an individual who may not be able to reach a place of safety unaided in an emergency situation, such as a building fire. These were kept in a folder near the front door.

At the last inspection we reported that no night staff had received fire marshal training to enable them to safely evacuate people from the home in the event of an emergency. The Vicarage employs a total of five night carers. At this inspection we found only one night carer had received this training and only two members of staff had fire awareness training. This meant that three out of five night carers had not had any fire training and could lead to instances where there would be night staff on duty who had not had any training.

At the previous inspection we identified concerns with fire safety and water safety checks and we contacted the local fire service and asked them to visit the premises to check that fire safety systems were in place and satisfactory. As a result of our referral, the fire service identified four deficiencies of The Regulatory Reform (Fire Safety) Order 2005 and issued a notification of deficiencies. The fire service returned to the home after this inspection and found they were still non-compliant. Due to our concerns identified at the last inspection, this time we were accompanied by a health and safety specialist advisor and found continued concerns regarding the safety of the equipment and premises. At this inspection we found concerns with water temperatures being too hot or too cold, basement fire hazard, unsafe grounds/garden and some equipment safety certificates. The deputy manager obtained and evidenced safety certificates for slings during the inspection. We also noted a number of required checks were not in place, such as risk assessment for asbestos and the home's gas safety check was overdue. After the inspection the provider produced evidence of the gas safety check being carried out two days after the inspection concluded. The specialist advisor spoke with the registered manager and highlighted their findings during the inspection and what improvements were required.

The above examples regarding, infection control, accident management and people's safety demonstrate a third consecutive breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

At the last inspection in May 2018 we found the registered provider was in breach of Regulation 18.1 Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because we found the home did not have sufficient numbers of staff on duty to keep people safe people were restricted in their movements around the home.

At this inspection we looked at staffing numbers at The Vicarage to ascertain if safe and appropriate levels of staff were on duty during the day and night. We reviewed the staff dependency tool with the deputy manager. People and visitors we spoke with told us they felt there was enough staff around to meet their needs and we observed staff present in the lounge where people spent their mornings and afternoons. We checked recent staff rotas and saw regular staffing levels were four carers and one senior carer during the day. Staff told us they felt more staff were needed. One staff member told us, "People are kept in the dining room and lounge to keep an eye on them as there is not enough staff. If we had more staff people would have more freedom to move around." We noted during the previous and this inspection that people were together in the one lounge in the morning before being moved into the dining room and then everyone returned to the lounge for the afternoon.

We found during this inspection that this these restrictions were still in place. People did not have access to the garden as there was not enough staff to supervise people in both the garden and the lounge. We identified that both dining rooms still had overhead latch locks on the outside of each door. Staff had previously told us the dining rooms were locked after mealtimes so people could not access them unaccompanied. This is restricting people's movement around the home. The deputy manager told us they had plans to remove these latches and unlocked them; however, they were still in place during this inspection and had not been removed by the end of the inspection.

We observed the lunchtime experience for people on both days of the inspection in both dining rooms. One dining room was mainly used by people who required little or no assistance and the other was used mainly by people who required more help with their meals. Where people required more support with their meals we found this to be a poor experience as there were not enough staff to appropriately assist them with their meals. Nine people at one sitting required assistance to eat their meals with three care staff present in the dining room, this meant that people were helped by more than one person and had to wait long periods as staff were assisting three people at the same time.

In the previous reports of January 2017 and May 2018 we reported the fire risk assessments from 2016 and 2017 stated current night staffing numbers were not sufficient in the event of an emergency and stated a minimum of three night-staff are required to ensure the safety of people.

At the last inspection we identified staffing levels for the night shift were insufficient. There were two carers on duty each night to support people over two floors and most of these people were living with dementia and others who may require the assistance of one or two staff for their personal care needs. We were also made aware that night staff have a task sheet to complete whilst on shift. These tasks include cleaning and laundry duties each night. The laundry was situated in the basement and therefore, one staff member would be left alone for a period of time to cover both floors of the home. The deputy manager told us all 23 residents are checked every two hours. This placed people and staff at risk if more than one person required assistance, if a person required the assistance of two people or there was an emergency. At this inspection we found improvements had not been made to night time staffing levels. During the inspection we received anonymous information regarding poor standards of care during night shift.

We found The Vicarage continued to be in breach of Regulation 18.1 Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the way in which medicines were managed at The Vicarage to check that people received their medicines in the right way at the right time. We found the medication room to be secure and temperatures daily for both the room and fridge were checked and recorded to be in ideal limits. We reviewed the medicines administration records (MARs) of five people and conducted a check to consolidate tablet

numbers. We found tablet numbers balanced and MARs had been completed. Individual medication records included information on allergies and included photographs to enable staff to identify the right person was receiving the right medicine. MARs for creams were also in place alongside body maps to indicate where they should be applied and how often. A safe system was in place to store and record the use of controlled drugs (CDs). The home used a local community pharmacy to manage the stocks and deliver the medicines. This included the local pharmacist checking and signing the MARs for accuracy of information.

During the inspection we looked at three staff personnel files to check that safe recruitment practices had been undertaken. We reviewed these files to check they contained required information including, a full work history, photographic identification checks, health information, a minimum of two references from previous employers and checks from the Disclosure and Barring Service (DBS). The DBS carries out checks and identifies to the home manager if any information is found that could mean a person may be unsuitable to work with vulnerable adults. We found that the personnel files contained all the required information. This meant that robust and safe recruitment practices had been followed to ensure that suitable staff had been employed to care for vulnerable people.

Requires Improvement

# Is the service effective?

## Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

In May 2018 The Vicarage was found to be in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance. This was because the registered manager or team leader was unable to tell us who living at the home had a DoLS in place and there was no system in place to track or review existing DoLS. At this inspection we found improvements had been made. The home had implemented a tracking system to ensure people were not being deprived of their liberty without the legal safeguards in place. However, we identified in one person's DoLS assessment there was condition attached to granting the legal safeguards that had not been met. This condition was the person was required to undergo a specific test. We spoke with the team leader and deputy manager regarding this condition and found no arrangements had been made to ensure this condition had been followed. We spoke with the deputy manager and requested they review all DoLS authorisations for people living at The Vicarage to check who had conditions in place, if they were being met and to ensure any conditions were being met.

We recommend the service ensures they record and action any conditions imposed on people's DoLS authorisations

During the last inspection in May 2018 we found staff we spoke with during the inspection demonstrated they had no knowledge around MCA and DoLS and were unable to tell us what this meant for people living at the home. At this inspection we looked at the training matrix that had been supplied to us and saw that no staff had received training in the Mental Capacity Act or DoLS. This may mean staff do not have an understanding of people's capacity and consent.

We spoke with the deputy manager about people living at the home who had legal documentation in place to allow another person to make decisions for them. The deputy manager was aware of one person who had lasting power of attorney for health and welfare, but was unaware if any other people had these legal safeguards in place. This meant there was potential risk that decisions may be made for people by others

who may not have the legal right to do so.

We observed on several occasions during the inspection where consent to provide support was not gained prior to care interventions. At the start of the inspection we did not see where people were asked if it was alright to take them to the dining room for their lunch; they were informed they were going for their lunch. We observed people being hoisted into wheelchairs without first being asked if it was okay to do so. We also saw where people were moved in their wheelchairs by staff without being asked or informed they were going to be moved. People were not asked where they would like to sit, they were taken there by staff. We reported this to the deputy manager who spoke with staff and later in the inspection we observed people's consent being gained.

The home has sensor alarms across people's beds that set off an audible alarm if the sensor beam was broken. The deputy manager told us they were in place to alert staff to someone falling or getting out of bed. However, staff told us everyone living at the home had these sensor beams in place, and activated each night, and no individual assessments had been carried out as to whether the person needed this measure or not. This meant that people did not have the choice to get out of bed without an alarm sounding. We did not see evidence that people had been consulted or consent gained to have this restriction in place.

We reviewed three people's care plans and looked at how consent to care and treatment had been sought and recorded. We found no evidence in these care files that consent had been gained. Consent forms were included as part of the care documentation; however, they had not been signed by the person or representative in the care plans we reviewed. One person did not have contact with family and we found they did not have an advocate to represent them or support them in making decisions regarding their care. A mental capacity assessment had been carried out by the team leader and the person had been assessed as lacking capacity to make decisions about their care. However, we identified the team leader had not had training in how to carry out mental capacity assessments. We did not find information within this person's care documentation on the person's preference for communication. We spoke with a staff member and they told us the person could communicate in some ways, such as writing things down, to let their wishes be known; however, there was no communication care plan their files to inform new staff. We identified the team leader had carried out a best interests decision with regards to the person choosing to live at The Vicarage. The person had not been involved in this decision nor been represented by someone who could advocate their wishes.

In another person's care files, we also found consent forms; however, none these had been signed. A best interest decision had been recorded regarding the person living at the home. Records of the decision showed that people who had been consulted were the registered manager, care staff and the team leader. There was no evidence anyone else had been consulted and the person themselves, or a representative, had not been involved.

The above examples demonstrate a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent.

During the inspection we looked at food choices available. There was a menu on the wall with two options; however, the cook told us they would make an alternative someone wished. They also discussed the menu with people on a one to one basis. People and their visitors told us they were happy with the food served at the home. One person told us, "The food is good and we are given a choice." One visitor told us, "The food has improved and my relative is well fed." We saw that people were offered drinks and biscuits in the lounge between meals.

We twice observed the lunch mealtime experience for people living at the home. The home has two dining rooms separated by a corridor. We found the décor and table settings had improved since the last inspection and clothes protectors had been replaced. People now sat at tables with tablecloths, napkins, mats, flowers and condiments. We observed two occasions where people had not eaten their meal and the cook offered them alternatives, which they then enjoyed. One person showed their appreciation after lunch by thanking staff and telling them that they enjoyed it.

At the last inspection in May 2018 we found that people had not been offered coloured plates, adapted cutlery or pictorial menus to assist them to choose their meals or eat independently. Coloured plates are an aid to independence and encourage people with dementia to eat more. At this inspection we found this had not been introduced and we saw that some people found using standard cutlery difficult and were using their hands to eat their meal. The provider has subsequently told us they have added pictorial menus and we will assess the effectiveness of these at our next inspection.

We had previously identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment. This was in relation to people with modified diets not receiving their meals in a safe way leading us to request immediate action be taken during the inspection to safeguard people. At this inspection we checked to see if improvements had been made and found new documentation had been introduced in order to minimise the risks to people from receiving their food and drink not as prescribed. People who required a modified diet were highlighted as such on the office whiteboard, dietician or speech and language (SALT) recommendations were contained in people's file, diet notification sheets were in place. We saw that some people had their drinks thickened or received meals that had been blended to make them softer for swallowing

At the previous inspection in May 2018 we identified a repeated breach of Regulation 18.2 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing. This was because we found the registered manager had not ensured staff were adequately trained and supervised to effectively care and support the people living at the home.

During this inspection we found a programme of staff supervision and a training matrix had now been introduced in order for the registered manager to have oversight of training levels. We saw evidence that several staff had attended supervision sessions. Staff told us they had received a number of policies and procedures via email; however, they told us they were expected to read these documents in their own time. The provider has subsequently told us this was the choice of staff and they would pay staff additional time to read them at the beginning or end of shifts.

The deputy manager provided us with a copy of their up-to-date training matrix that showed current staff training levels. We found no competency checks were carried out to check staff performance and we identified significant shortfalls in the levels of up-to-date training. For example, half of care staff had not received training in pressure sore awareness, despite the people's care plans we reviewed containing risk management plans for skin integrity. We identified people at the home had suffered a high number of falls; however, the matrix showed only three out of eighteen care staff had received falls awareness training (no night staff had received this training). Nine members of staff who had not completed any training on safeguarding people. This meant that some staff members may not be identify potential abuse or know how to report it. We signposted the deputy manager to the Skills for Care website for further information on staff training. One visitor we spoke with told us, "I don't think staff are trained" and "They (staff) need training on dementia."

The above examples demonstrate a third consecutive breach of Regulation 18.2 of the Health and Social

Care Act 2008 (Regulated Activities) Regulations 2014. Staffing

At the previous inspection in May 2018 we made a repeated recommendation that The Vicarage consider current guidance on dementia friendly environments to make the home more conducive to the people living at the home. At this inspection we found improvements had been made to the environment and we could now see use of photographs on doors to aid people to orientate them around the home and there was evidence of contrasting colours being used to aid independence, for instance on grab rails and bathroom / bedroom doors. Photographs and names had now also been introduced on people's bedroom doors along with a sentence around what people are like or what they liked to do.

During this inspection we reviewed three people's personal care files to check if people were supported to maintain their health and well-being. We saw people were supported to access other health care professionals, such as the district nursing service and dieticians alongside other services, such as an optician. We spoke with one visiting professional who told us they had no concerns when they visited about the people and had noticed improvements to the home's environment in the past six months. They told us the registered manager "keeps the staff on their toes, [name] is very on the ball" and they had no concerns regarding the home's management of people's skin integrity. They told us they always received referrals in a timely manner.

Visitors we spoke with told us they were happy with the way staff kept them informed around how their relative was, they told us, "We always are aware of what's going on, they will ring if there are any concerns." And "I am always consulted prior to any decisions on [Name's] care."

Requires Improvement

# Is the service caring?

## Our findings

People we spoke with who lived at The Vicarage told us they felt well cared for at the home, one person told us, "All the staff are good. They know me and are very good. They look after me and I can talk to them all." Another person told us, "It's good here, I like it."

We received mostly positive comments from visitors around the care at the home. One visitor told us, "Staff are so lovely. I've always been happy, they've always done everything I have asked. I can't ask for more." Another visitor said, "The atmosphere feels safe and content. I have never seen anything that has caused me to question anything." However, one visitor commented, "It could be better. They are improving the place slowly."

At the previous inspection in May 2018 we identified a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Dignity and respect. This was because people were not always treated in a respectful way and we reported two incidents where staff were unkind to people to the registered manager.

At this inspection we found improvements had been made. We observed polite and respectful interactions between people and staff. We saw staff smile at people and they smiled back. People looked happy and content. Staff were chatting and engaging with people in the lounge area. We noted during the inspection there was a pile of blankets on a sideboard. The weather was cold during the inspection and people stated on several occasions that they were cold in the lounge and staff covered people with a blanket.

At this inspection we found elements of the care provided which continued to require improvement. We observed several times where people were assisted to stand or hoisted to a wheelchair. This was mainly done in a caring way whilst explaining the movement and reassurance given to people; however, we also saw instances where this was done without explanation or reassurance.

At the previous inspection we identified equality and diversity had not been considered or addressed for the people living at the home. At this inspection we found although equality and diversity training had been identified for staff, no staff had received this training. Staff we spoke with told us they had not been given information around this subject. This meant that people were at potential risk of receiving care and treatment from staff who were not aware of the need to ensure people with protected characteristics were respected. Protected characteristics are a set of nine characteristics that are protected by law to prevent discrimination

At the previous inspection we found a 'bath schedule' was in place at the home. The team leader had told us people had a choice but they were not offered a bath unless it was 'their day' to be offered one. The only bath people had access to was a very old sit up style shower as there was no regular-sized bath in the home. This 'bath schedule' did not afford people dignity and choice. We observed not all the people living at the home looked groomed nor had their hair brushed. At this inspection we found the 'bath schedule' was still

in place and some people did not look clean and cared for. We noted several people's hair had not been brushed and some people had dirty finger nails.

At the last inspection we reported that bedding was old and in poor condition. At this inspection we found improvements had not been made to the condition of people's bedrooms and bedding. We found furniture in some people's bedrooms was old and in poor condition and bedding was so threadbare it had become transparent in places. We noted in one person's care files that they felt the cold at night and their preference was to have a quilt and extra blanket on their bed and wear a bed jacket. We visited this person's room and found only a thin quilt, thin blanket and staff were not able to locate the person's bed jacket. We also found the person's bedroom window was open at 4pm and their radiator had been turned off and the staff member who accompanied us, was not able to explain why. This meant the person's room was extremely cold as the weather was snowing during the inspection.

These examples demonstrate that people's dignity at the home was not always respected and demonstrate a repeated breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Dignity and respect.

During the inspection we noted several closed circuit television (CCTV) cameras were situated high on walls in communal areas of the building. The registered manager told us the CCTV was currently out of operation and not being used. The registered manager will need to ensure they are aware of and meeting their legal obligations around CCTV if they were to reinstate the system.

Requires Improvement

# Is the service responsive?

## Our findings

We reviewed three people's care documentation and found they included care plans and risk assessments, we found one care plan where improvements had been made to the information recorded and included details, such as what the person liked to do for activities. The deputy manager told us not all care plans had yet been updated to the improved versions; however, they were currently working through them so they could record what people like to do. We found there was no information to confirm how individuals, family members and other people had been involved in developing, understanding and reviewing plans of care.

The Accessible Information Standard denotes that information is required to be presented and communicated in such a way as to meet the individual needs of people with a disability, impairment or sensory loss. We did not find evidence throughout the inspection that attention had been given to assessing and meeting people's individual needs around accessing and understanding information. One staff member told us they were aware of three people who could communicate by writing things down. We checked one of these people's care files and did not find any information to inform staff of this and their communication care plan was not completed.

At the last inspection we found there was no programme of activities and the one activity provided at the home was armchair aerobics. This activity was still in place at the home, which we observed during this inspection and we saw that the people involved really enjoyed the session. The deputy manager told us that as a result of the last inspection findings, they had employed an activities co-ordinator and had purchased resources for providing activities, such as craft items and board games. However, the activities co-ordinator had left the home some time ago and had not been replaced. A whiteboard had been placed on a wall in the corridor of the home to display what activity was on that day; staff told us there was no set programme in place but more of an on the day decision of what to offer. We found the only person to visit the home to provide entertainment was the armchair aerobics instructor. Staff told us they were expected to run the activities themselves on top of their carer duties. One staff member told us, "A co-ordinator would be better because if one staff member is doing the activity then the other residents are put at risk due to their falls risk." And, "There's more time to do things at weekends, but during the week it's difficult to find time."

People we spoke with told us they looked forward to activities and wished they had it more often. Relatives we spoke with commented there was not enough entertainment to occupy people and would like to have more organised, outside entertainment. One visitor told us, "They need to bring people in, for example, schools or animals…I never see carers come in and stand people up, people just sit around for hours at a time." On the first day of inspection we observed a staff member playing a board game with people and a DVD was put on one of the televisions in the lounge.

We found that despite people's individual activity preferences recorded in care plans, no personalised activities were offered at the home. Staff we spoke with told us there was no programme in place to ensure people received personalised activities and some people have a religion, but no-one from the church visits anymore; however, they told us, "sometimes the nuns pop in." We noted there were no magazines or daily

newspapers for people to browse; however, staff told us sometimes a relative may bring one in.

At the previous inspection in May 2018 we identified a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people did not have access to the procedure regarding making a complaint and to whom. At this inspection we found some improvements had been made. We noted in the reception that a compliments and complaints box had been placed for people to post their comments. The deputy manager told us they were currently in the process of updating the complaints policy and procedure. We reviewed the recorded complaints and saw a small number had been recorded and responded to. People we spoke with told us they would speak to the manger if they wanted to complain. One person told us, "I could speak to the manager if I wanted anything." Another person told us, "I would ask the carer or the manager if I wasn't happy with something."

Inadequate

# Is the service well-led?

## Our findings

The home had a manager in post who had been registered with the Care Quality Commission (CQC) since October 2010 at this location.

A registered manager has responsibility under their registration with the Care Quality Commission to have regard, read, and consider guidance in relation to the regulated activities they provide, as it will assist them to understand what they need to do to meet the regulations. At the previous inspection in May 2018 we found that the registered manager did not have knowledge and documentation that showed us they were aware of their obligations. At this inspection we found improvements had been made to the home's communal areas, information sharing and documentation. However, we identified continued breaches of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection we identified a continued breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009. This was because statutory notifications to inform us of significant incidents at the home had not been submitted to CQC as required since 2016. During this inspection we found this was a third consecutive breach.

Also at the previous inspection we identified a breach of regulation 16 of the Care Quality Commission (Registration) Regulations 2009. This was because statutory notifications to inform us of the death of a person had not been submitted to CQC as required since 2016. During this inspection we found this was a repeated breach.

The registered manager for this service is also the registered manager for a similar sized home in Tameside and is also the registered provider and nominated individual for both services. We found at the last inspection there was a lack of management structure in place; at this inspection we found they now had the help of a deputy manager and a part-time administrator.

Since the findings of the last inspection the local authority had suspended placements and the registered manager had received assistance from the local authority quality improvement team (QIT). The QIT went into the home one day per week and the registered manager had purchased a quality compliance system of policies and procedures to implement at the home. We saw evidence of the introduction of this system by the way of files for policies and procedures, and improvements to some people's care documentation. However, this new system had not yet been fully implemented and the necessary improvements were not always in place in order to ensure the safety of the people and improve the experience for people living at the home.

We noted that although some auditing of the home had now been carried out, the concerns that had been identified had not always been actioned and we found the same concerns during the inspection and outlined in this report. For example, an environmental risk management plan had been completed in October 2018 and had identified several bedrooms had an offensive smell, no call bell cords, concerns

regarding internal bedroom locks and equipment worn and unclean. A risk assessment for the garden dated April and September 2018 had identified it was unsafe noting that people were not to access the garden without a member of staff. We found the Notice of Deficiencies issued by the fire service in July 2018 had not been fully complied with. We received this information after they re-inspected in February 2019.

Throughout the inspection we fed back our findings, highlighting immediate concerns and the identified concerns and sought assurances that the shortfalls would be addressed.

The above examples demonstrate a third consecutive breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

The deputy manager told us they had now implemented a daily walk around the home and had introduced staff meetings to pass on information to staff. We saw that improvements in the amount of detail recorded had been made to the shift handover sheet since the last inspection.

We looked at how the service gathered feedback to gain the opinions of people living at the home. We saw a survey had been carried out regarding seating arrangements and meals and a survey regarding how happy people were with the new décor in communal areas.

Feedback we received from people and their visitors regarding the management of the home was positive. We asked people and their visitors if they had seen improvements at the home recently and they all agreed. One visitor told us, "There has been several improvements in the décor over the last few months." Another visitor told us, "The food has improved and my relative is well fed."

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 16 Registration Regulations 2009 Notification of death of a person who uses services<br><br>The commission had not received the necessary statutory notifications as is the requirement. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 Registration Regulations 2009 Notifications of other incidents<br><br>The commission had not received the necessary statutory notifications as is the requirement. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>People were not always clean. People's bedrooms and bedding were in poor condition. People were not always treated in a dignified way at mealtimes. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>Consent was not always sought before care delivery. Documentation showed consent had not always been sought in line with the MCA 2005. |

| Regulated activity | Regulation |
|---|---|

| | |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>People's bedrooms were not always clean. Action had not always been taken to safeguard people regarding accidents. There was no first aid provision at the home. Concerns regarding the health and safety of the building were identified. People did not have call bell cords in their rooms. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>We identified repeated breaches of the regulations. Statutory notifications have not been sent to CQC. Previously identified concerns had not always been acted upon. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>There was not enough suitably trained staff on duty to provide safe and effective care. |