UG Care Limited

The Old Vicarage

Inspection report

Ford Street
Wigmore
Near Leominster
Herefordshire
HR6 9UW

Tel: 01568770564
Website: www.theoldvicaragewigmore.co.uk

Date of inspection visit:
11 January 2024

Date of publication:
01 March 2024

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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
The Old Vicarage is a residential care home providing accommodation and personal care for to up to 16 people. The service provides support to older people some of whom live with dementia. At the time of our inspection there were 13 people using the service.

People's experience of the service and what we found:
People and their relatives told us they felt safe and were positive about the service, however, we found risks to people's health and well-being were not managed robustly. Practices did not always promote good infection, prevention and control.

Medicines were not always managed safely for people living at the service.

There were enough staff to meet people's needs and staff were recruited safely.

Not everyone was supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests as the provider had not ensured all requirements under the Mental Capacity Act (MCA) and authorisations under the Deprivation of Liberty Safeguards were fully met.

Some areas of the home were in need of refurbishment. Improvements could be made to the environment to support people living with dementia.

Care was not always person-centred and did not promote people's dignity, privacy and human rights.

Systems to monitor and improve the quality and safety of the service were not always effective. The provider had not always sent us statutory notifications which is their legal responsibility to do so for notifiable incidents. Policies and procedures were not always in line with current legislation and guidance. The registered manager informed us they were looking at introducing a new quality assurance system.

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

Rating at last inspection
The last rating for this service was Good (published 8 September 2019).

Why we inspected
We undertook this inspection due to the length of time since our last comprehensive ratings inspection. We undertook a focused inspection to review the key questions of Safe and Well-led. During the inspection we found there was concerns with the environment, storage of confidential information, dignity and respect, so we widened the scope of the inspection to include Effective and Caring. For the key question not inspected,

Responsive, we used the rating awarded at the last inspection to calculate the overall rating.

You can read the report from our last comprehensive inspection by selecting the 'All inspection reports and timeline' link for The Old Vicarage on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to management of risks, medicines management, dignity, safeguarding and good governance.

Please see the action we have told the provider to take at the end of this report.

Follow Up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

The Old Vicarage

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspection team consisted of 2 Inspectors and an Expert by Experience.
An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
The Old Vicarage is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. The Old Vicarage is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations. At the time of our inspection there was a registered manager in post.

Notice of inspection
The inspection was unannounced.

What we did before the inspection
We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and

improvements they plan to make. We sought feedback from the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We used all this information to plan our inspection.

During the inspection
We spoke with 6 people using the service and 1 relative about their experience of the care provided. We spoke with 5 members of staff including the registered manager who is also the nominated individual and deputy manager. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We viewed 3 people's care records and 5 people's medication records. We looked at a variety of records relating to the management of the service, including policies, procedures, and audits.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management
- Improvements were required in the way risks to people were managed.
- Environmental risks had not all been assessed or mitigated. We found keys to the medicine's cupboard had been left in the door, and the lock on the medicines trolley was broken which meant medicines were not secure.
- Wardrobes had not been secured to walls in people's bedrooms. This meant there was a risk of people being injured by these falling or moving.
- Not all windows had been fitted with window restrictors. This meant there was a risk people may fall or climb out of windows.
- Some fire doors were found to be held open by unauthorised means. This had also been identified in an external fire risk assessment completed in November 2023.
- Cleaning items including buckets and hoovers were stored in fire escapes and in front of fire extinguishers.
- Several fridge items were not labelled with their opening and use by dates. This meant there was a risk these items would be used past their recommended shelf lives putting people at risk of potential food poisoning.

The provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following the inspection, the provider confirmed window restrictors had been fitted to all upstairs windows, wardrobes had been secured and door wedges removed.

Using medicines safely
- Medicines were not managed safely.
- People's prescribed medicinal creams were not stored in a safe way. We saw creams in people's bedrooms which were not locked away as per national guidance. Some creams we found did not have a date of opening recorded and some creams had gone past their expiry date. The provider could not be assured these medicines were still safe to use.
- Medication administration records (MAR) had not been kept up to date when changes to medicines had occurred. Some medicines which had been stopped had not been updated on the MAR. This increased the risk of people not being administered medicines in line with their prescription.
- Some people had medicines administered using patches. The site of application was not recorded and there was no documented monitoring to confirm the patches remained in place. Medicines that are

administered through patches often require site rotation to ensure that medicines are absorbed evenly into the body.
● Protocols were not in place for people who required their prescribed creams or medicines to be given 'as required' (PRN), this meant staff responsible for administering medicines did not have the guidance on how and when to administer.
● One person using the service required their medicines to be administered covertly. There was no guidance with the MAR charts to instruct staff how these should be administered safely.

Systems to manage medicines safely were not effective. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider acted following our feedback to improve medicines management, for example the lock on the medicine trolley was replaced and missing protocols were completed.

Systems and processes to safeguard people from the risk of abuse and avoidable harm; Learning lessons when things go wrong
● People were not always safeguarded from abuse and avoidable harm.
● Processes in place to ensure safeguarding concerns were reported and investigated appropriately were not effective. For example, we found entries in records relating to unexplained bruising that the provider had failed to investigate or escalate in line with national guidance.
● Systems used to record accidents and incidents were not used effectively. For example, no entries had been made for the whole of 2023 despite care records identifying incidents had occurred. This meant the provider was not identifying patterns trends or learning from events which had occurred.

Systems and processes were not effective in safeguarding people from potential abuse. This was a breach of Regulation 13 Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite our findings people told us they felt safe. One person said, "I feel very safe here."
● Staff received training in safeguarding and understood the different types of abuse.
● The provider held staff meetings following our inspection to share the issues we identified and how they could learn from this.

Preventing and controlling infection
● People were not always protected from the risk of infection as staff were not consistently following safe infection prevention and control practices. For example, personal protective equipment (PPE) had been disposed of in a wastepaper bin in the lounge.
● Some areas of the service could not be effectively cleaned, such as chairs and flooring as they were damaged.
● Parts of the kitchen were not clean. Some surfaces including the top of the fridge, and the floor in the food storage area had a build-up of dust dirt and food debris.

Staffing and recruitment
● Safe recruitment practices were in place to ensure only staff suitable to work with vulnerable people were employed. These included Disclosure and Barring Service (DBS) checks which provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● Staffing levels in the service were assessed by the provider, depending on people's needs using a

dependency tool. We saw there were enough staff to meet people's needs during our visit.

Visiting in Care Homes

- People were able to receive visitors without restrictions in line with best practice guidance.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

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

- The provider was not always working in line with the Mental Capacity Act.
- Mental capacity assessments were carried out however, these did not follow the principals of the Mental Capacity Act. For example, a person using the service received their medicines covertly (so the person did not know they were taking medicine). We saw staff had not completed mental capacity assessments to identify if this person had capacity to consent to taking their medicines; not had best interest meetings taken place. The service did not have protocols in place to support staff to assess patients for the purpose of administering covert medicine.
- However, some people were supported by an advocate to ensure decisions were in accordance with the Mental Capacity Act 2005. An advocate is an independent person who can help someone express their views and help ensure their voice is heard.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People had their needs assessed before moving into the service.
- Care plans were in place about how to support people, however, for 1 person, care records had conflicting information regarding the number of staff that were required to provide them with support.
- Systems to assess people's risks were based on best practice guidance. For example, Waterlow assessments were used to see if people were at risk of developing skin damage.

Adapting service, design, decoration to meet people's needs

- People's individual needs were not always met by the adaption, design and decoration of the premises
- The environment was not always suitable to meet the needs of people using the service. For example, there was a lack of visual prompts for people living with dementia to help promote orientation and independence.

● However, people using the service told us there were areas within the service they enjoyed spending time, 1 person told us they liked to go outside to see the goats and chickens and feed the birds.
● Items of furniture and carpets required replacing. This was discussed with the registered manager who confirmed following the inspection the chairs had been removed and replacement carpet had been ordered.

Supporting people to eat and drink enough to maintain a balanced diet
● People were not always supported to eat enough to maintain a balanced diet.
● People's weight was not consistently monitored and the provider had not put sufficient measures in place when people had experienced unintentional weight loss. This meant people were at risk of malnutrition.
● However, people were provided with meals to meet their needs, for example one person who did not eat meat was given a vegetarian option.
● One person told us, "I've improved and stabilised, the staff have helped me get good nutrition and hydration."
● We saw, and people told us drinks were readily available. One person told us, "We get drinks every couple of hours, but I can ask for one if I want one."

Staff support: induction, training, skills and experience
● Staff received induction and training and their competencies checked in areas such as moving and handling.
● Various training courses were available for staff to provide them with the skills and knowledge required to meet people's needs.
● People were positive about the staff's knowledge of their support needs.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People were supported to access a variety of health professionals. The nurse practitioner visited the service regularly and the GP visited as needed.
● Referrals to specialist healthcare professionals were made. For example, one person was referred to the speech and language therapy team.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant people were not always well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence; Ensuring people are well treated and supported; respecting equality and diversity

- People's privacy, dignity and independence were not always respected and promoted. For example, doors to some people's rooms and communal bathrooms had glazed panels which were not fully covered. This meant other people using the service, staff and visitors could see through into people's private space.
- Language staff used about people in records was not always respectful; for example, care records described 1 person as, 'can be difficult".
- Information detailing people's continence products were displayed throughout the service where other people and visitors could see to see. This compromised people's dignity.

Failure to have suitable arrangements in place to protect people's privacy and dignity was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following our inspection, the provider acted on our feedback and removed all signs and covered the glazed panels.
- Despite our findings, people spoke positively about the support they received.
- People we spoke with told us they were well treated. One person said, "They [Staff] have always been very good and know me as a person not just a resident and are very approachable."

Supporting people to express their views and be involved in making decisions about their care

- People were not always supported to express their views and make decisions about their care.
- There was limited evidence the provider had engaged people and their relatives in making decisions about their care. One person and a relative told us, they had never been asked to fill in a questionnaire or survey or go to a meeting. The registered manager told us they had not held a relatives meeting since before COVID-19, but were planning to start them again.
- Reviews of care plans were not consistently undertaken, nor were people supported to express their views or be involved in making decisions about their care. People could not recall when their care review was last completed.

Requires Improvement

Is the service well-led?

Our findings

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

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Continuous learning and improving care

- The systems the provider had in place to monitor quality and safety were not effective and had not identified the concerns found on this inspection.
- Audits and checks of medicines had failed to identify the concerns we found during inspection.
- There was no evidence of learning or action plans to help improve the service, so people living at The Old Vicarage could have a better overall experience. For example, where external audits had been completed the actions identified had not been signed off as completed and internal audits did not identify areas for improvement.
- Care records had not been consistently reviewed. For example, 1 person's care review had not been completed since April 2023. This meant the provider could not be assured care plans were person centred and reflective of their current needs. We found limited evidence of people's involvement in their care reviews.
- We found records in communal places meaning these could be accessed by people living at the service and visitors.
- The provider had failed to notify CQC of significant events that happened in the service as required by law. This included allegations of abuse, and DoLS authorisations.
- The providers policies and procedures did not always meet the requirements of national guidance .

The provider's systems and processes had failed to robustly assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider acted following our feedback and had started to address the concerns we had raised.

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

- The provider held meetings with people and staff regarding the running of the service and sought their views through surveys. The registered manager told us they had not had any meetings with relatives since before COVID-19 but were hoping to start these soon.

● The culture in the home was not always person centred. Not all people were being supported to engage in activities which were meaningful to them. One person felt activities were geared towards people living with dementia. Another person told us, "I'm fed up of the TV all the time. There's nothing else to do."
● Relatives told us they were kept informed of their family members well being. One relative told us, "They [Staff] ring if there is anything to tell us."
● Staff worked with other health and social care professionals, such as GPs, Nurses and social workers.

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 10 HSCA RA Regulations 2014 Dignity and respect Suitable arrangements were not in place to ensure people were treated with dignity and respect consistently.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment An effective system was not fully in place to assess, monitor and manage risk in relation to the environment, medicines, and infection control.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not effective in safeguarding people from potential abuse

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were either not in place or robust enough to assess, monitor and improve the quality and safety of the service or mitigate the risks relating to the health, safety and welfare of people.