Vicarage Care Limited

The Old Vicarage

Inspection report

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Ratings

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

Overall summary

This unannounced inspection took place on 12th January 2015. We last inspected The Old Vicarage on 3rd January 2014. At that inspection we found the service was meeting all the regulations that we assessed.

The Old Vicarage is a residential care home providing personal care and accommodation for up to 30 people with a range of care and support needs. The home is in a residential area in the village of Ireleth, within walking distance of local shops, the railway station and the bus stop. There is some car parking available to visitors. The home is on two floors with a single storey extension and a stair lift to provide access to the first floor. There is a secure garden area to the side with seating for the people living there. On the day we visited there were 27 people living in the home.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 and associated Regulations about how the service is run.

Summary of findings

We spoke with people in their own rooms and those who were sitting in the communal areas. They told us that they felt “safe” and “well looked after”. We saw that people were treated with kindness and respect by the care staff. People we spoke with told us, “I am happy living here” and “They (staff) look after us very well”.

Staff we observed going about their work were patient and polite when supporting people who used the service. We observed staff supporting people to eat their meals at a pace dictated by the person eating. Staff supported people to maintain their dignity and were respectful of their privacy and respected their choices. Activities were on offer at the service and people told us how they were able to go out and access activities in the local community.

People’s personal and social needs were assessed and care plans were developed to identify what care and support people required. Staff worked with other healthcare professionals to help make sure specialist advice and support was accessed to help ensure people received the care and treatment they needed.

Medicines were handled safely and people received their medicines as their doctor had prescribed. Medicines were stored safely and records were kept of medicines received and disposed of so all could be accounted for.

The home had moving and handling equipment and mobility aids to meet people’s different needs and to help promote their independence. The home was being maintained and we found that all areas were clean and free from lingering unpleasant odours.

The registered provider had safe systems when new staff were recruited and all staff had appropriate security checks before starting work. The staff employed were aware of their responsibilities to protect people from harm or abuse.

The service followed the requirements of the Mental Capacity Act 2005 Code of practice and Deprivation of Liberty Safeguards. This helped to protect the rights of people who were not able to make important decisions themselves.

There were processes to monitor the quality of the service and we saw from recent audits that the service monitored areas of practice and made improvements where identified. We found that the manager knew what training staff needed and this was arranged for them but the monitoring systems used were not easily verifiable for overall monitoring purposes.

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?

Good

The service was safe. Staff understood their responsibility to safeguard people and what action to take if they were concerned about a person's safety.

Staff had been recruited safely. There were sufficient staff to provide the support people needed, at the time they required it.

Medicines were handled safely and people received their medicines appropriately. Medicines were stored safely and records were kept of medicines received and disposed of so all could be accounted for.

There were processes in place for reporting incidents and we saw that these were being followed and monitored.

Is the service effective?

Good

The service was effective. Staff working in the home received training relevant to their roles to make sure they were competent to provide the support people needed.

People had a choice of meals, drinks and snacks. Where the home had concerns about a person's nutrition they involved appropriate professionals to help make sure people received the correct diet.

The management and staff worked well with other agencies and services and people received the support they needed to maintain their health.

People's rights were being protected because the Mental Capacity Act 2005 Code of practice and Deprivation of Liberty Safeguards were being followed and applied in practice.

Is the service caring?

Good

The service was caring. People told us that they were well cared for and we

saw that the staff treated people in a kind and friendly way. The staff were patient and discreet when providing support to people and promoted privacy and dignity.

Staff demonstrated good knowledge about the people they were supporting, for example detailed information on their backgrounds, their likes, dislikes and preferred activities.

Is the service responsive?

Good

The service was responsive. Assessments of need and individual preference had been undertaken and care plans developed to identify people's health and support needs. The care plans had been reviewed and updated to respond to any changes in need.

There were plans in place to reduce the risk of people becoming socially isolated and activities were planned each day. People told us they had the opportunity to do 'everyday' activities in the community such as going shopping, attending local clubs or going out for a walk.

There was a system in place to receive and handle complaints or concerns raised.

Summary of findings

Is the service well-led?

Good

The home was being well led. People who lived in the home and their visitors were asked for their views of the service and their comments were acted on. Staff told us they had the opportunity to meet regularly and could raise any concerns or questions they had about the service.

Processes were in place to monitor the quality of the service and action was taken when it was identified that improvements were required.

The manager knew what training staff needed and this was arranged for them but the systems used were not easily verifiable for overall monitoring purposes.

The Old Vicarage

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 checked 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 12 January 2015 and was unannounced. The inspection was carried out by the adult social care lead inspector and an expert by experience (ExE). An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During the inspection we spoke with eight people who lived in the home, three relatives/visitors, five care staff, domestic staff and the registered manager and one of the directors of the company. We observed care and support in communal areas and spoke to people in private and communal areas. We also spent time looking at records, which included looking at five people's risk assessments and care plans to help us track how their care was being planned and delivered. We also looked at staff rotas, staff training and supervision and records relating maintenance and the management of the service and records regarding how quality was being monitored.

At this inspection we also looked at medicine management, storage, administration and disposal. As part of the inspection we also looked at records, medicines and care plans relating to the use of medicines.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. It is a tool to help us assess the quality of interactions between people who use a service and the staff who support them.

Before our inspection we reviewed the information we held about the service. We also contacted the local authority and social workers who came into contact with the home to get their views of the home. We looked at the information we held about notifications sent to us about incidents affecting the service and people living there. We looked at the information we held on safeguarding referrals, concerns raised with us and applications the manager had made under Deprivation of Liberty Safeguards (DoLS).

We had not received a Provider Information Return (PIR) from the registered manager. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The registered manager told us they had difficulty saving this document but that they had returned it, although we had no record of this. The registered manager was able to provide us with information they had sent when we visited.

Good

Is the service safe?

Our findings

Everyone we spoke with who lived at The Old Vicarage told us that they felt they were safe and well cared for living at the home. People living there told us, "I'm happy living here, they (staff) make sure I keep safe" and "I feel very safe in the home". One person said, "I feel very safe in the home" and another person told us, "I trust them and like them (staff), and they always know what to do".

The supervisor and care staff we spoke with told us about the training they had recently done in recognising and reporting possible abuse and in managing behaviour that might challenge the service. All the staff we spoke with knew the appropriate action to take and said they would be confident reporting any concerns to a supervisor or the registered manager. When there had been any safeguarding incidents at the home the registered manager had referred incidents to the appropriate agencies. Staff told us that "No one here is restrained" and that they had "On- going training on this" and "There are strategies in place to ensure service users safety and they are in the care plans".

The care plans we looked at had been regularly reviewed so that people received appropriate care. We looked at the risk assessments in place for people that identified actual and potential risks and the control measures in place to try to minimise them. People's care plans included risk assessments for skin and pressure care, falls, moving and handling, mobility and nutrition.

The balance between protection and freedom of choice was being managed and people were supported to make their own daily choices and take part in activities outside the home as well as within. For example going out with friends and going into the village.

We found that the home was clean and tidy and was being maintained and there was a rolling maintenance plan for the year. Records indicated that the mobility equipment in use had been serviced and maintained under contract agreements and that people had been assessed for its use.

There were records of the monthly maintenance checks being done on fire alarms, fire extinguishers and emergency lighting. Records indicated that fire drills and fire training had taken place. The registered providers had an independent fire survey done on the premises and had made changes to systems to improve fire safety procedures and fire alarms as a result.

There were contingency plans in place to manage foreseeable emergencies and people had individual emergency plans in place to appropriately support people if the home needed to be evacuated. This helped to make sure that people were safe living in the home. There were processes in place for reporting incidents and we saw that these were being followed and monitored.

There was a stable staff team and those we spoke with were able to tell us about the needs of the people they were supporting. On the day we visited there were sufficient numbers of appropriately trained care staff on duty to keep people safe and enough kitchen and cleaning staff to support them. There was a supervisor on duty during the day and an on call system for night staff to get help or advice if needed from senior staff. Staff we spoke with told us that "usually no problems" with staff levels. People living there told us, "There always seems to be plenty about". We saw that people received their care and support in a timely manner.

The registered manager had good systems in place to ensure staff were only employed if they were suitable and safe to work in a care environment. We looked at the records of three staff that had been recruited before our inspection. We saw that all the checks and information required by law had been obtained before the staff were offered employment in the home. A Disclosure and Barring Service (DBS) check had been completed before people had started working in the home

As part of this inspection we looked at medicines records, supplies and care plans relating to the use of medicines. We also looked at how medicines were stored and found that they were stored safely and records were kept of medicines received and disposed of. We saw that the staff administering the medicines had received training to do so. For example the supervisory staff had done training on the management of anticoagulant medication to promote safe practice (these are medicines to prevent blood clotting). We saw that staff giving out medicines gave people the time and the appropriate support needed to take their medicines.

Good

Is the service safe?

There were protocols in place to help make sure staff gave people “as required” medicines safely. This included information on what the medicine was, why it was being given and when it could be given. We looked at the handling of medicines liable to misuse, called controlled drugs. These were being stored, administered and recorded correctly. Refrigerator temperatures were monitored and the records showed that medicines were stored within the recommended temperature ranges to help prevent any deterioration.

Good

Is the service effective?

Our findings

We joined people at the lunch time meal and saw that it was a calm and pleasant time. People who required support with eating received this in a patient and respectful way with staff helping and prompting people with their meals. People told us that they enjoyed their meals and always had a choice. One person told us, "I like the food, it's very good, I always clear my plate".

We used the Short Observational Framework for inspection, (SOFI) to observe how people in the communal and dining areas of the home were supported as they had their midday meal. Care staff assisted people who needed some help to eat their meals and there were plenty of hot and cold drinks available on the tables at lunch time and in the lounges throughout the day. There was a choice of food at the mealtimes. As we spent time in different communal areas of the home we saw that the staff engaged positively with people and we saw people enjoyed talking with the staff.

All of the care plans we looked at contained a nutritional assessment and a weekly or monthly check on people's weight for monitoring. We saw that if someone found it difficult to eat or swallow advice was sought from the dietician or the speech and language therapist (SALT).There was also information on specific dietary needs such as gluten free, diabetic diets and soft and pureed meals. This information was recorded in people's care plans and had been regularly reviewed to monitor progress. Where the home had concerns about a person's nutrition they had involved appropriate professionals to help make sure people received the correct diet.

People had access to health care professionals to meet their individual health needs. The care plans and records that we looked at showed that people were being seen by appropriate professionals to help meet their physical and mental health needs. We saw records in the care plans of the involvement of the community mental health team, district nurses, medical and psychiatric consultants as well as opticians, chiropodists and dental services.

A member of staff told us, "Our training is on-going and alters if we have a new resident who has a different need". We looked at individual training records where staff recorded their individual training and saw that staff had a range of training relevant to their roles in addition to mandatory training. This included training on end of life care, dementia awareness, the Mental Capacity Act 2005, handling different behaviours and effective communication.

Staff and supervisors we spoke with told us that they thought they had "good access to training" and knew what training was being planned for the next month. Care staff confirmed that they received regular supervision from the supervisors who in turn had supervision from the registered manager. Newer staff told us that they had received induction training over a 12 week period and had 'shadowed' more experienced staff when they started to work in the home. We saw that they had records in their personnel files of their induction and when a senior member had signed off their training as part of competence assessments on induction.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005 (MCA). The MCA and DoLS provide legal safeguards for people who may be unable to make decisions about their care. We spoke with staff to check their understanding of MCA and DoLS. Staff we spoke with demonstrated an awareness of the codes of practice and the process to assess someone's capacity to make a decision. A person living there told us "I am always asked nicely, nobody just tells me what to do".

We saw that the registered manager had raised potential restrictions that might affect people's freedoms with the managing authority responsible for this to make sure they were acting in line with the legislation. We could see in care records where people had given their consent to care and support and also where decisions had been made following a 'best interests' process to help make sure people's individual rights were upheld.

Good

Is the service caring?

Our findings

The people who lived in the home we spoke with told us they were "happy" and "very satisfied" with the care and support they received at The Old Vicarage. One person told us, "It's been a good home for me. I like it here, if I didn't I wouldn't stay". Another person told us "I think the girls are good, we have a bit of a laugh with some, it's what makes the world go round". We were also told, "They're all good, kind and see the funny side of things- you have to have a sense of humour with us lot".

We were told by people living there that staff knew their likes and dislikes and "Always tell us what is going on or ask me what I want doing". One person told us "I always like to dress smart, you can't let yourself go". We saw that staff had made sure they were appropriately dressed and with their jewellery and make up. We saw during our SOFI observations that people who could not easily speak with us were comfortable and relaxed with the staff who were supporting them.

Some people used items of equipment to maintain their independence. We saw that the staff knew which people needed pieces of equipment to support their independence and provided these when they were needed. This included providing people with their walking frames, seat cushions to relieve pressure when sitting and the correct use of moving and handling equipment. We saw that when care staff assisted people with their mobility they made sure that people's clothing was arranged to promote their dignity. This helped to maintain people's dignity and independence.

One person who lived there told us "They (staff) are very caring and help me live quite an independent life". They told us the particular ways they felt staff did this and the arrangements that were made so that they could go out and follow their own interests. Another person told us, how staff helped them shop in the village if they wanted to get some shopping. Staff were able to tell us about how they supported individuals to follow their own interests and to be as independent as they could be. One person living there we spoke with told us that taxis were arranged for people to go into the nearest town to do their own personal shopping and the taxi waited to bring them back when they were ready. They told us they appreciated being able to do this for themselves. We saw that people were supported and encouraged to do as much for themselves as they were able to.

We found that a range of information was available for people in the home to inform and support their choices. This included information about the providers, the services offered and about support agencies such as advocacy services that people could use. An advocate is a person who is independent of the home and who can come into the home to support a person to share their views and wishes. We saw that one person had used the services of a mental health advocate to help and support them when making some decisions about care and support.

The care staff we spoke with understood the importance of providing good care at the end of a person's life. Care plans contained information about people's care and treatment wishes should their condition deteriorate. We could see in some people's care plans where 'Six Steps' holistic care assessments had been done to monitor and support their care needs as their conditions changed. 'The Six Steps' palliative care programme aims to enhance end of life care through promoting organisational change and supporting staff to develop their roles around end of life care.

We saw that staff knocked on the doors to private areas before entering and ensured doors to bedrooms and toilets were closed when people were receiving personal care. During our visit we saw that staff approached people in an informal and supportive way using their preferred names as stated in their care plans. We saw that people who could not easily speak with us were comfortable and relaxed with the staff helping them.

Good

Is the service responsive?

Our findings

All of the people that we spoke with told us that routines in the home were flexible and that they made choices about their lives and activities. They told us they chose where to spend their time, where to see their visitors and how they wanted staff to help. We spoke with people in all the communal areas and we received positive comments about daily life in the home. We were told, by one person that their care was "focused on me" and that they could go out if they liked to and that visitors could come "anytime". We were told by another person, "I get up when I am ready, I can have a sleep in if I want to and have some breakfast in my bedroom".

The service had a complaints procedure that was on display in the home for people living there and visitors to refer to. There had been two complaints received by the registered manager since our last inspection. We saw that complaints that had been received were recorded and the action taken in response to complaints was recorded and had been dealt with by the registered manager. Records showed what had been done and how it was being monitored. The Care Quality Commission had not received any complaints about the service in the twelve months before we carried out this inspection.

People who lived there we spoke with told us they had not felt the need to make a complaint and we were told "I have no complaints" but that they knew how to complain if necessary and would feel comfortable raising anything they were not happy about. We were told "If I did not like something I would complain to the manager or supervisor, but I have not had to".

Care plans showed that assessments had been done to identify people's care and support needs. We looked at care plans for five people and saw that these had been regularly reviewed so that people continued to receive appropriate care. Assessments had been done to identify people's care and support needs both before and following admission and plans had been developed saying how these should be met. We saw that where they could people had been involved in putting what they wanted in their care plans and where possible had signed to agree the contents.

People's health and support needs were stated in their care plans. There was personal background information in people's plans called 'All about me' that was aimed at informing staff and personalising support. Staff we spoke with had a good knowledge of people's backgrounds, families and lives before they lived there. This helped staff when they communicated with and supported people as it helped them understand particular behaviours or anxieties. People told us the staff who supported them knew how they liked to be helped and did this promptly.

People told us about the activities in the home they could attend if they wanted and some had attended a local 'pensioner's club in the village. Some people did not want to take part or preferred to spend time in their rooms and this decision was respected. One person told us, "I don't like to go out now, I like to stop in and watch the telly, I can watch whatever I like".

Information on people's preferred social, recreational and religious preferences were recorded in individual care plans. People were able to follow their own religions and faiths and take part in multi denominational services if they wanted to or see their own clergy. People told us that "If there was anything going on" that day the staff would remind them. A reminder of the days planned activities was displayed in the main foyer. The rotas indicated that a member of staff was designated each day to make sure the activities went ahead as planned and support people to participate either in groups or on a one to one basis.

Good

Is the service well-led?

Our findings

We saw during our inspection that the supervisors and the registered manager were accessible and spending time with the people who lived in the home and engaging in a positive and open way with them. The registered manager was very knowledgeable about the people living there. One person told us that the care staff spent time with them and they saw the registered manager "Every day to talk to" and another said, "They (staff) come up and have a sit and natter with us".

The home had a registered manager in place as required by their registration with the Care Quality Commission (CQC). Feedback we received from the main funding authority was positive about the service provision. All the staff we spoke with told us that they were supported in their work and had access to the training they needed. Staff told us they had meetings with their supervisors to discuss practices, share ideas and any areas for development and that supervisors were always on duty with them. This helped to make sure that staff had the opportunity to raise any concerns and to discuss their performance and development needs as they needed in the workplace.

The registered manager had also distributed satisfaction surveys to people living there so they and their relatives could give feedback to management. This was done annually and the most recent survey showed a good level of satisfaction. We saw that a suggestion was made to have more varied organised activities had been looked at and was being addressed. This included having a staff member designated with this responsibility and having a better planned programme of daily activities people could take part in if they wanted. People we spoke with told us they were "always" told what was going on and asked if they wanted to join in.

There were systems in place to assess the quality of services in the home and to get people's views about the service provision. We could see that people had the opportunity to attend 'resident's meetings' that were held at different times of the year to give their views and talk about how the service was being run for them. We saw from the minutes of the last meeting that menus and suggestions for new menu items had been discussed. The suggestions made had been followed up, for example having more pasta dishes and also pizza on the menu. These actions indicated to us that the staff and registered manage had listened and responded to suggestions made by the people who lived there.

We saw that regular audits had been done on care plans and care records, medication records and the premises and environment. We could see from these where any changes had been made in order to make sure the systems worked better or any errors addressed with staff. For example, the medication audit had picked up the need to dispose promptly of 'as required' medicines people no longer needed. Also care plan audits had picked up the need for greater clarity around recording details of any advocacy services being used.

Maintenance checks were being done regularly by staff and records had been kept and we could see that any repairs or faults had been highlighted and acted upon. There was a maintenance plan in place for the year and that included redecoration and renewal.

The manager knew what training staff needed and this was arranged for them but the monitoring systems being used were not easily verifiable for overall monitoring purposes. The records for some staff did not make it clear if their training was current and up to date as there was no overview of all staff training to make it clear where everyone's training was up to at any time. From the records being kept it was not clear if all the staff had received regular training and updates on best practice on topics including infection control, food hygiene and safe moving and handling.

We discussed this with the registered manager, who also took the lead on infection control. This was not a large home and the registered manager said they knew all their staff well and so was able to tell us what training was needed, by whom and when it would be done as well as keeping their own record. However there was a lack of a clear and verifiable system for monitoring all staff training in a systematic way. This meant a high level of reliance on informal monitoring and personal staff knowledge rather that a verifiable monitoring system showing the training position of all staff at any one time. It was unclear what the annual training plan was for everyone for the year ahead and how it was to be tracked to make certain all staff training and induction had been completed and was effective.

Good

Is the service well-led?

The registered manager discussed with us how they would address this to improve and formalise the system and make it easier to track and show their planning and the training completion. This information, and the way we could see the registered manager had previously acted when audits/suggestions had indicated a need to change something, indicated to us that they were open to feedback to improve the service provided.