Care Quality Commission

Coate Water Care Company (Church View Nursing Home) Limited

Mockley Manor Care Home

Inspection report

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Ratings

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

Overall summary

This inspection took place on the 26 January 2015 and was unannounced.

Mockley Manor is registered to provide both nursing and personal care for a maximum of 52 older people. 45 people were living in the home at the time of our visit.

We last inspected the home in August 2014. After that inspection we asked the provider to take action to make improvements in care provision and to ensure people's needs were met by sufficient numbers of appropriately skilled staff. At this inspection we found improvements had been made in these areas, but further improvements were still required.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered

Summary of findings

providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe living at Mockley Manor and staff understood their responsibility to report any observed or suspected concerns. Where potential risks had been identified with people's care, we saw the correct equipment was in place to reduce the risks such as mobility aids.

Although staff thought there were sufficient staff to meet people's needs safely, we found there was a delay in responding to requests for support. Improvements were needed to ensure people received the same level of care throughout the day.

Staff received training in areas considered essential to meet people's needs safely and consistently. However, there were limited training opportunities to develop staff knowledge of specific health issues. Staff had not received training in the Mental Capacity Act 2005 and their understanding of the legislation was not always clear.

The manager had made appropriate applications to the local authority in accordance with the Deprivation of Liberty Safeguards and was following legal requirements.

Staff were caring and compassionate in their approach to people. People were given choices about how they wanted to spend their day so they were able to retain some independence in their everyday life. Family and friends were able to visit when they wished and staff encouraged relatives to maintain a role in providing care to their family member.

There were a range of activities available for people living in the home that promoted their wellbeing. Staff responsible for providing activities were enthusiastic and encouraged the wider community to support the home.

Staff understood people's healthcare needs and people were supported by external healthcare professionals to ensure their needs were fully met.

There was a stable management team in place who were consistent in their understanding of the challenges faced by the service. Staff felt supported by the registered manager and told us they would feel confident to raise any concerns or issues.

There were processes in place to assess the service which fed into an action plan to ensure improvements were made in the quality of service provided.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

People told us they felt safe and staff understood their responsibility to report any observed or suspected abuse. Staff told us they were very busy and during the mornings there was often a delay in meeting people's needs. People received their medicines as prescribed but some of the processes around the safe management of medicines needed to be improved.

Requires Improvement

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

Staff received the training considered essential to support people but training about specific health needs was limited. Staff required further support to fully understand the requirements of the laws to support people who lacked mental capacity. People's healthcare needs were met with support of other healthcare professionals.

Requires Improvement

Is the service caring?
The service was caring.

People were treated with kindness and compassion. Staff were respectful of people's relationships with family and friends. They supported relatives to maintain a role in caring for their family member.

Good

Is the service responsive?
The service was responsive.

Staff demonstrated a good understanding of the health and support needs of each person who lived in the home. People's social needs were met through a range of activities that were provided on both a group and individual basis by staff who were enthusiastic about their role. People could be confident any complaints would be dealt with and responded to in line with the complaints policy.

Good

Is the service well-led?
The service was mostly well-led.

There was a stable management team in place and staff were positive about the support provided by the registered manager. The management team were consistent about the challenges faced by the service and acknowledged that a stable staff team would enable the registered manager to concentrate on the managerial aspects of their role.

Good

Mockley Manor 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 26 January 2015 and was unannounced.

The inspection team consisted of two inspectors, a specialist advisor in nursing and an expert by experience. The expert by experience was a person who had personal experience of caring for someone who had similar care needs.

We reviewed the information we held about the service. We looked at information received from relatives and other agencies involved in people's care. We looked at the statutory notifications the manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. We also contacted the local authority contract monitoring officer. They had no new information to share with us.

We asked the provider to complete a Provider Information Return (PIR). This form had been returned by the provider and gave some key information about the service, what their service does well and improvements they plan to make.

During our inspection visit we spoke with the registered manager, the deputy manager, the operational manager, seven care staff and two non-care staff. We spoke with eight people who lived at the home and four relatives. We carried out observations in the lounge and dining room to see how people received their care. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us to understand the experience of people who could not talk with us.

We looked at a range of records about people's care and how the home was managed. We looked at care records for seven people to see how they were cared for and supported. We looked at other records related to people's care including medication records, the services' quality assurance audits, records of complaints and incidents and accidents at the home and records relating to staff.

Requires Improvement

Is the service safe?

Our findings

When we last visited Mockley Manor in August 2014 we found there were insufficient staff to meet the needs of people who lived in the home. At this visit we found some improvements had been made, but we still identified concerns around delays in staff meeting people's needs.

People we spoke with felt there were sufficient numbers of staff in the home. However, one person we spoke with told us they did not feel there was enough staff. They explained, "I press my bell but I don't get any answers. There is no one about. They vanish. Staff say I am busy, what do you want."

Staff told us that whilst they felt there were enough staff to meet people's needs safely, there were times they had to ask people to wait for support, particularly in the mornings. Comments included: "It's good [staffing] but sometimes we are rushed. Sometimes people can wait about 30 minutes for the toilet, but it doesn't happen often." "Sometimes buzzers ring for a few minutes. I get there as quick as possible but sometimes people wait for the toilet." "The mornings are the worst. You only have a set amount of time. We have time to do the necessary but if people need the toilet, we have to make them wait, about 20 minutes. Mornings and afternoons are different. More time in the afternoon. You feel awful saying you have to wait." A relative told us people became agitated because when they asked for personal care they had to wait so long before it was provided.

During the day we saw staff were very busy. Call bells were ringing but they were answered in a short period of time. However, we did observe two occasions when people asked for support with their personal care and were asked to wait. One was at lunch time when a person asked to be assisted to go to the toilet. They were told, "You will have to wait, we are in the middle of dinners, there are not enough people." The person was still waiting to be assisted to the toilet when we left the lounge 30 minutes later. Another person who was cared for in bed informed staff they required personal assistance. This person was at risk of skin damage so it was important their personal care was managed promptly. Staff did not provide assistance until we reminded them 30 minutes later. Staffing levels in the home meant there was a delayed response in seeing to people's needs.

We asked the manager how staffing levels were determined in the home. They told us they used a tool which identified whether people were high, medium or low dependency. This tool then informed the level of staffing required in the home. We looked at the tool. We found that no allowance had been made for the extended layout of the building on the first floor. One staff member told us, "Staffing levels have changed but people's dependency levels have increased."

The identified staffing level in the home was two nurses on duty during the day or one nurse and a senior carer. We were told that one nurse would not be able to administer all the medicines in the home so senior carers administered medication to support the nurse. We looked at staffing rotas. Rotas showed that on four of the previous eight days, there had only been one nurse on duty during the day. On two of those days there was no senior member of care staff on the rota to assist with medication. We were told measures had been implemented to ensure medicines were administered safely, however, this meant the provider was not meeting their own required skill sets on every shift.

We found this was a breach of Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010. Staffing.

People told us they felt safe at Mockley Manor. One person told us, "I am safer here than in my own home alone." A relative told us they were planning to go on holiday and felt confident to leave their family member at the home. They went on to say, "[Person] is in a safe place and I trust the staff."

Staff we spoke with demonstrated an understanding of their role in keeping people safe and protecting them from harm and abuse. Staff had received relevant training and understood their responsibility for reporting any concerns and who to report those concerns to. One staff member told us, "It is about making sure people are safe and not in danger."

The manager understood their role in the safeguarding process. They had reported safeguarding concerns to the local authority safeguarding team and to us.

There was a system in place to make sure care staff were recruited appropriately to ensure they were safe to work with people who used the service. Staff disciplinary procedures were followed where issues were identified in their work practice.

Requires Improvement

Is the service safe?

We looked at seven care files. We saw there were risk assessments in place to identify where people were at risk of falls, malnutrition, pressure areas or transferring, such as from bed to chairs. Where potential risks had been identified with people's care, we saw the correct equipment was in place to reduce the risks such as mobility aids to safely transfer and mobilise people.

People we spoke with were happy with the management of medicines in the home and told us that staff responded promptly to any requests for pain killers.

Medicines were kept in locked medicine trollies. Temperature records were not maintained of the rooms where the trollies were stored so we could not be sure medicines were stored at the correct temperatures to ensure their effectiveness. Medicines that were required to be kept at lower temperatures were kept in accordance with manufacturer's instructions.

Each person had their own section in the medication administration folder with a photograph on the front of their records to reduce the chances of medication being administered to the wrong person. We looked at the Medicine Administration Records (MAR) for three people. Staff had signed to record the administration of a medicine or a reason was documented to explain why the medicine had not been given.

Information was not always available to guide staff on when to safely administer medicines prescribed "when necessary" for agitation. We further noted that when people were given a medicine prescribed for agitation, there was no record to explain why the medicine had been given. A lack of records could lead to inconsistency in the administration of these medicines.

One person was sometimes administered their medicines concealed in drink. There was a signed agreement between all interested parties that it was necessary for the person to be administered their medicines 'covertly' to maintain their health and wellbeing. The pharmacist had been consulted to ensure the covert medicine was administered safely.

There was a maintenance schedule in place to make sure the environment was safe and equipment was kept in good working order. This included a system of internal inspections of equipment and maintenance by external contractors.

The provider had plans in place to ensure people were kept safe in the event of an emergency or unforeseen situation. Emergency equipment was checked regularly. Each person had a personal emergency evacuation plan which explained what support they required to keep them safe if the building had to be evacuated. A central record of these plans was accessible to the emergency services. There was a contingency plan in place to inform staff what action to take if there was a cut in services such as gas or electricity.

Requires Improvement

Is the service effective?

Our findings

People we spoke with told us they thought the staff were trained to meet their needs. One person said, "I am satisfied with the care I receive here and staff understand my needs."

Staff told us that when they started to work at the home they completed an induction which was a mixture of learning and shadowing experienced staff. One member of staff told us, "I completed on- line training which included basic training and I spent one week shadowing an experienced member of staff."

Staff told us they received training to support them in ensuring people's health and safety needs were met. This included moving and handling, health and safety and infection control. We saw staff put this training into practice. For example, staff moved people safely and understood how to use the equipment. Staff had not received training to provide them with further knowledge about managing and supporting the specific needs of people who lived in the home. For example, diabetes or Parkinson's Disease. During our visit we observed staff undertaking tasks but when we spoke with them, they did not have a clear understanding of why they were undertaking the tasks. For example, why one person was being weighed more regularly than others in the home. Further training would support staff in understanding people's clinical needs so they could respond in a more informed way and provide more effective care. This would be of particular importance when there was only one nurse on duty with clinical oversight for everyone in the home.

Care records in the home were computerised. At our last visit in August 2014 we identified some care staff were not accessing care records to update them because they had not had training. At this visit we found some staff were still reluctant to access the computer. One member of staff explained they were "nervous about computers". Staff required further support to ensure they felt confident to use the care system operated by the provider.

We looked at how the provider was meeting the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA ensures that the human rights of people who may lack mental capacity to take particular decisions are protected. DoLS are required when this includes decisions about depriving people of their liberty so they get the care and treatment they need in the least restrictive way.

We saw that people had mental capacity assessments in place in relation to decisions about their every day care. The registered manager told us they had identified that the assessments were not specific enough to individual decisions and planned to introduce new capacity assessment forms. We saw the new forms were much more detailed to ensure the most appropriate decision in the circumstances was made and to prevent unnecessary intervention in people's lives.

Staff had not received training in the Mental Capacity Act so we talked to them about their understanding of capacity and consent. Staff understood issues around consent and told us they would not provide care for people who did not consent. Comments included: "You must ask permission." "You must ask them. I explain what I am doing, even if they have dementia. They are still a person." "I recognise non-verbal signals. One lady upstairs, she will let you know because she becomes still if she doesn't want anything. I just leave them and go back later." However, staff had limited understanding about how the MCA was put into practice in their work, what this meant for people, or how they could support people who did not have capacity. We spoke with the manager about what we had found. They told us training in the MCA was planned for all staff.

The registered manager understood the requirements and implications of the DoLS legislation and the effect it can have on people. DoLS applications had been submitted and approved when restrictions on people's liberty had been identified.

People were provided with sufficient to eat and drink. People told us they had a choice of meals and enough to drink during the day. One relative told us, "We notice [person] likes the food here, we haven't tried the food, but the smell is very good." We observed the lunchtime meal which was relaxed and unhurried. People were able to eat their meal where they preferred. We spoke with the chef who told us they had a list of people who required a special diet or who needed their food fortifying with extra calories. This list was updated weekly to ensure people's nutritional needs were met.

Requires Improvement

Is the service effective?

People received safe and coordinated care and treatment from healthcare professionals involved in their care. The registered manager told us the home's GP visited every Tuesday and was very supportive. There were regular clinical meetings with the GP and the pharmacist to discuss best practice within the home. Records showed people had received care and treatment from other health care professionals such as speech and language therapists, dieticians and chiropody. Appropriate referrals had been made in a timely way.

Since our last inspection we had received information from two healthcare professionals who visited the home. They were both positive about the level of care provided and the "holistic approach to person centred care".

Good

Is the service caring?

Our findings

People we spoke with told us staff were caring when providing support. One person told us, “Staff are very pleasant and helpful.” Comments from relatives included; “The staff are very friendly, they are also very courteous to everyone.” “I feel very welcome and staff also offer you a cup of tea”. “The staff here make an effort to know you by name and this makes us comfortable.”

We spoke with staff about what caring meant to them. One staff member responded, “I look after people’s needs.” Another told us, “I treat them as a person. I take my time with them. I am just here for them.”

During our visit we observed some positive and caring interactions between people and members of staff. Staff spoke reassuringly to people, providing physical comfort such as stroking people’s arms and hands. One person got upset at lunch time because they could not cut the meat on their plate. A member of staff spoke reassuringly saying, “Don’t worry, it’s not you, it’s possibly the knife.” The person seemed less upset and accepted help from the care worker when they returned with a different knife.

At lunch time we observed a member of care staff supporting a person to eat who was unable to speak or see. When the staff member spoke to the person, the person’s facial expression showed recognition and affection.

We observed staff offered people choices and provided them with the opportunity to make every day decisions.

People were asked what they wanted to eat and drink and where they wanted to go in the home. Staff respected the decisions people made which meant people had control over aspects of their daily care and support. Where people required some assistance, it was provided in a relaxed and unhurried manner that did not deprive them of their independence. For example, people who wanted to mobilise independently were supervised at the person’s own pace. We spoke with one person who was in bed on the day of our inspection. They told us they had got up the day before, but it was their preference to remain in their room that day. They explained, “They [staff] leave me where I am happiest.”

We observed staff promoting people’s dignity during our visit. The meal time was a sociable occasion with tables laid with tablecloths, napkins, cutlery and condiments. Some people wore aprons to protect their clothes, but people were given a choice to wear one or not. People were encouraged to make their room personal to them and were able to bring in furniture, pictures and ornaments to make the room their own.

Staff were respectful of people’s relationships with their families and friends. The home had an open house policy and visitors were welcome at any time of the day. We saw that families and those closest to people were encouraged to maintain a role in caring for their family member, such as providing support at mealtimes. People told us that relatives could close the bedroom door at any time when visiting their family member to maintain their privacy.

Good

Is the service responsive?

Our findings

When we last inspected the service in August 2014 we asked the provider to make improvements in the provision of care within the home. At this visit, we found improvements had been made.

People we spoke with were satisfied with the quality of care delivered within the home. One family member told us, "We've had our ups and downs but it takes time to get to know someone." Another relative said, "[Person] is very happy here and I am quite confident with staff at the home as they know more than me because they are with [person] 24/7. I am happy to see that [person] is comfortable and has been looked after well."

All care records were computerised and could be accessed by two computers in the office or by laptop. We were told there were two laptop computers available within the home. Care plans covered all aspects of a person's individual care needs, the support they needed and how these were met. Each person had a named qualified nurse who was responsible for the review and updating of the care plans. The deputy manager explained, "We have a chart. It is supposed to be done monthly but some need doing."

Staff were inconsistent about how often they had the opportunity to read care plans but demonstrated a good understanding of the support people required. All the staff spoken with advised of the pivotal role shift handover played in communication and being able to respond to people's needs. The sheet used in the handover process highlighted people's basic needs and identified those people with increased risks such as diabetes and the equipment required to support people when mobilising.

There were two activity co-ordinators employed at the home. We spoke to one of the activity co-ordinators during our visit. They explained that their role was to establish people's interests and hobbies and provide activities that met their individual needs. We found the activity co-ordinator was very sociable, friendly and enthusiastic for their role. They explained, "We all want to feel part of something. It's good to involve people." A relative told us, "[Person] is always in his own world, but I noticed when the activity worker plays bingo I can see a smile on his face. He [activity worker] encourages people to participate and also offers choices."

We saw people were supported to participate in group activities and also individual activities. This included people who preferred to stay in their rooms to prevent them becoming socially isolated. One person was helped to use SKYPE to speak to a relative who lived abroad. This helped the person to maintain a relationship with someone who was unable to visit regularly.

There were plans to improve the garden and make a woodland area. Feeding stations were being put in place for birds and wildlife to provide focal points of interest outside the home and stimulate conversations. People from the wider community were involved in helping carry out the improvement plans. The activities co-ordinator explained, "It's getting the community in here, people here love it. I am trying to get the wider community involved."

All the people we spoke with were positive about the social activities provided. One member of staff described how the activities and social interventions had a beneficial effect on people, especially those who could sometimes display behaviours that could be challenging. For example, they had recently introduced two guinea pigs into the Namaste Suite which had a positive, calming effect on a person who could become agitated.

People were provided with information about how they could raise a complaint in the information pack they were given when they started to use the service. The service had received three complaints since our last visit in August 2014. We saw complaints were recorded, investigated and responded to in a timely way. Meetings had been held with people to discuss their concerns. People could be confident any complaints would be dealt with and responded to in line with the complaints policy.

Good

Is the service well-led?

Our findings

The home had a clear, stable management team in place. There was a registered manager in post who was supported by a deputy manager. The registered manager understood their responsibilities and had sent notifications to us as required. The deputy manager was the clinical lead in the home and worked on the rota as one of the nurses. They had a set number of protected hours each week to carry out their managerial duties.

Staff we spoke with were positive about the support they received from the registered manager. Comments from staff included: "[Manager] mucks in, not all managers do that, I have a lot of respect for her." "I feel supported by management." It was clear the registered manager had a "hands on" approach and was willing to provide nursing cover during shifts when a need was identified. The manager explained, "I will do a shift to see what is happening and how things are going. I like to do the medication, it is a way of auditing and checking routines. " The week before our visit the registered manager had worked on the rota as one of the nurses on five days. On two of those days the registered manager was the only nurse on duty with clinical oversight of everybody in the home. Whilst this enabled the registered manager to have a good working knowledge of the challenges faced by staff during a working day, this impacted on the time available to carry out their managerial responsibilities.

The registered manager and operational manager were consistent in what they thought were the key challenges faced by the service. They told us, "The main challenge is staffing issues. We find it difficult to recruit nurses and care staff." They confirmed the registered manager was covering nursing shifts in preference to using agency staff as they understood the needs of the people living there. The provider was currently recruiting for two nursing positions which would enable the registered manager to concentrate on the management of the home.

Staff told us the registered manager was "very approachable" and they could "approach her at any time". Staff were confident to voice their concerns to the registered manager. Minutes of staff meetings confirmed staff were given the opportunity to raise any issues that may be of concern to them and that issues were discussed in an open and frank manner. One staff member told us they would welcome more regular team meetings to build team relationships and provide an opportunity to do some joint problem solving.

During our visit we observed the registered manager interacting and speaking with people. She clearly knew people well and was fully aware of their individual likes and dislikes. People were observed to respond well and were comfortable with her.

Arrangements were in place to assess and monitor the quality of service provided. Each month the registered manager completed a report which recorded any incidents, accidents and falls. This also recorded information about people with weight loss and infections. This was analysed by the operations manager to identify any trends or patterns so action could be taken where necessary.

A service action plan was in place which provided a structured timetable for identified improvements in service provision. The plans identified the member of staff responsible for carrying out the actions. The operational manager explained they had supervision with the manager regularly to ensure the actions were completed in accordance with the plan.

There was a programme in place to improve the environment for people who lived at the home and their visitors. The décor in the older parts of the home looked rather 'tired' but there was an extensive refurbishment programme taking place at the time of our visit. The outside grounds required some attention, but we were advised by staff that plans were in place to refresh the look of the home and landscape the gardens.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **There were not always sufficient staff with the right knowledge, experience, qualifications and skills to support people.**