Mandeville Care Services Limited

Mandeville Grange Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 17 and 22 December 2015. It was an unannounced visit to the service.

Mandeville Grange Nursing Home is a care home for older adults, some of whom may be living with chronic illness or dementia. It is registered to provide accommodation for 31 people. At the time of our inspection 25 people lived at Mandeville Grange Nursing Home.

We previously inspected the service on 21 August 2013.The service was meeting the requirements of the regulations at that time.

The service had a registered manager in post. 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.

Mandeville Grange Nursing Home is located within a converted Georgian family home. It had a home from home atmosphere. Rooms were personalised and people had access to a wide range of activities.

There was a potential for people to receive incorrect doses of medicine. Medicines were not always managed in line with best practice. We found the service lacked space to store medicine safely and more medicine was stored than was required.

People were protected from avoidable harm as staff had received training and were able to recognise signs of abuse. Staff knew what actions they would take if a safeguarding concern was raised.

Risk assessments were undertaken and staff were aware of how to minimise risk to people.

Staff were aware of people's needs; they had knowledge of people's lives prior to moving into the home. Staff spoke with people in a dignified manner, and sought consent from individuals prior to care provided.

People were supported by staff who had awareness of the Mental Capacity Act 2005 and Deprivation of Liberty (DoLS). Where needed appropriate referrals were made the Local Authority to authorise a DoLS.

The provider and registered manager were clear about their vision to provide person centred care to people. They invested in staff members' education to enable them to perform a quality service. Staff felt supported by management and told us they were confident to address any issues with them.

We found a breach of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

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.

People were support by staff who did not store controlled medicines safely and in line with national guidelines.

People were protected from harm because staff received training to be able to identify and report abuse. There were procedures in place for staff to follow in the event of any abuse happening.

People's likelihood of experiencing injury or harm was reduced because risk assessments had been written to identify areas of potential risk.

Is the service effective?

Good

The service was effective.

People were encouraged to make decisions about their care and day to day lives. Decisions made on behalf of people who lacked capacity were made in accordance with the Mental Capacity Act 2005.

People were cared for by staff who were aware of their roles and responsibilities.

People had access to food and drink through the day.

Is the service caring?

Good

The service was caring.

Staff were knowledgeable about the people they were supporting and aware of their personal preferences.

People were treated with dignity and respect.

Is the service responsive?

Good

The service was responsive.

People were able to identify someone they could speak with if

they had any concerns. There were procedures for making compliments and complaints about the service.

People were supported to access a range of healthcare and appointments were made promptly when needed.

Is the service well-led?

Good

The service was well-led.

People's needs were appropriately met because the service had an experienced and skilled registered manager to provide effective leadership and support.

People could be certain any serious occurrences or incidents were reported to the Care Quality Commission. This meant we could see what action the service had taken in response to these events, to protect people from the risk of harm.

Mandeville Grange Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on the 17 and 22 December 2015 and was unannounced; this meant that the staff and provider did not know we were visiting. The inspection was carried out by one inspector.

Before the inspection the provider completed a Provider Information Return (PIR). The PIR is a form that the provider submits to the Commission which gives us key information about the service, what it does well and what improvements they plan to make. We reviewed notifications and any other information we had received since the last inspection. A notification is information about important events which the service is required to send us by law.

We spoke with four people living at Mandeville Grange Nursing Home who were receiving care and support, two relatives, two healthcare professionals, the registered manager and six staff. We reviewed five staff files, four care plans and three medicine records within the service and cross referenced practice against the provider's own policies and procedures.

Requires Improvement

Is the service safe?

Our findings

One person told us "I am very safe living here." Another person told us "I have no reason to feel unsafe, staff are always around."

We observed medicine being administered at the correct time and when requested by people Good hygiene techniques were carried out prior to administration of medicines. Staff members explained what the medicine was for and allowed people time to take the medicine. Where medicines were prescribed for 'when required' use (PRN), protocols were in place. These detailed the reason for the medicine and situations when it should be used. Risk assessments were undertaken to assess if a person was able to self-administer medicine. Medicine administration records (MAR) were completed appropriately. People we spoke with stated that they received their medicine on time.

General medicines were stored safely in a locked cabinet, only staff who needed access to the cabinet had it. However we found the service did not follow national guidance from The Royal Pharmaceutical Society on the safe storage of Controlled medicines. Controlled medicines are those that require stricter control under the misuse of drugs legislation..

On the second day of our inspection we asked a nurse to show us the storage and records for the amount of controlled medicines. We found that controlled medicines were not stored appropriately so that there was a risk that staff could not fully account for amount of medicine stored, which could lead to over ordering and misuse. We found one controlled medicine that had been prescribed for PRN use. Two small doses had been administered in the monthly medicine period checked, however there was in excess of 600mls in stock. This meant that storage space was lacking for controlled medicines and therefore some controlled meds were not stored appropriately. Dispensing dates did not always correlate with the dates marked on the containers.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with did not make any comments regarding staffing levels; however staff and the registered manager acknowledged that on occasions the service needed more staff. The registered manager had a set level of staff they aspired to have on duty at all times. This number was based on the dependency levels of people living at Mandeville Grange. On day one of our inspection we were informed that two staff had not arrived for a shift. We observed staffing interaction during the day and spoke with people who use the service. The low staff levels did not appear to affect the care received by people. There was good teamwork throughout the day. The registered manager worked tirelessly to try to increase staffing numbers. They advised us they had an on-going advert with recruitment agencies. Staff we spoke with were happy to work additional hours and were enthusiastic about their role.

People were supported by staff with the appropriate experience and character to work with vulnerable people. The service operated robust recruitment processes. Pre-employment checks were completed for

staff. These included employment history, references, and Disclosure and Barring Service checks (DBS). A DBS is a criminal record check. Where staff were awaiting a full enhanced DBS, a first response check had been undertaken. The registered manager had identified this as a risk and the staff did not work alone with people living in the service. This protected people from the risk of harm until all clearances were received. Where qualified staff were appointed appropriate checks were in place to ensure that they were able to practice as a nurse.

People were protected from the risk of abuse. The service had a safeguarding procedure in place. Staff received training on safeguarding people. Staff had knowledge on recognising abuse and how to respond to safeguarding concerns. Staff had access to the local safeguarding team contact details. Staff informed us that they would contact that team or the Care Quality Commission (CQC) if management did not report safeguarding concerns. People we spoke with stated they knew who to speak with if they had any concerns. Where concerns were raised about people's safety or potential abuse, the service was aware of the need to report concerns to the local authority and also their requirement to report this to CQC.

People were protected from other potential risks and the service had a risk management policy. Risk assessments were written for a wide range of activities including falls and bed rails. Risk assessments were reviewed on a regular basis. Changes in conditions or risk were recorded.
We noted one person had been identified as at high risk of falling from bed. Actions required were recorded to minimise the risk. When we checked the person's room it was clear the actions recorded were in place and observed by staff.

Environmental risks were identified and managed. Equipment used regularly by the service was maintained and repairs conducted when needed. Hoists in place were serviced; water and gas safety checks were undertaken and certificates were in date. Incident and accidents were recorded and the registered manager conducted a monthly audit to evaluate trends.

The service had procedures in place to deal with emergencies. Personal emergency evacuation plans were in place for each person. These detailed the support people required in the event of an emergency. Fire procedures were displayed in many areas within the service. Staff were knowledgeable on what to do in the event of a fire. Along with regular fire alarm tests, when the fire alarm was activated all staff were expected to respond. The service kept a record of the activations which detailed what prompted the alarm, which staff responded and what actions had been taken if staff did not respond appropriately.

The service was supported by a team of domestic and maintenance staff. The environment was kept clean and odour free. One person commented "my room is hovered every day, and the tables are always kept clean."

Good

Is the service effective?

Our findings

People's needs were met by staff who had access to the training they needed. Staff had received training which included; end of life, wound care and the care certificate. The care certificate sets out explicitly the learning outcomes, competences and standards of care that will be expected by health and social care workers. Staff we spoke with were working towards qualifications appropriate to their role. Staff told us they had the training they needed to meet people's needs. We noted the registered manager kept a record of what training staff had received and prompted people to attend training when required. One senior care worker spoke very highly of the care certificate qualification which they had recently completed.

New staff were supported through an induction period. This included a period of time when new staff would work alongside more experienced staff. These shadow shifts were highlighted on the rota as additional staff members. This allowed time for teaching and sharing of skills. Qualified staff we spoke with advised they worked alongside new care staff to help them develop into the role.

Staff we spoke with advised us they received supervision meetings and annual appraisals. There were records of these meetings. Supervision sessions were in part, an observation of staff practice. We spoke with the registered manager about this. They informed us that this method allowed a discussion to take place about quality of care and skills demonstrated which in turn helped to drive up the quality of the service. The records we looked at did not demonstrate that staff received supervision in line with their own policy. The registered manager was aware this was the case and was going to be addressing this issue all line managers. However the impact on the staff was low, as the members of staff we spoke with felt supported.

Where English was not the first language of care and catering staff, the service provided on site English language training. We spoke with the teacher and they advised that training was centred on increasing knowledge of verbal and written communication. The teacher devised training around specific roles within the service. For instance a care worker's learning would be concentrated around knowledge of good communication in gaining consent to care and treatment.

Staff we spoke with were knowledgeable about the people they supported. One staff member gave a full account of a person's life history and their likes and dislikes. Staff were aware of their responsibilities and limitations. Care staff advised they would speak to a qualified member of staff when needed.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA), and whether any conditions on authorisations to deprive a person of their liberty were being met.

The 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 when this is in their best interests

and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We observed that where people required one, a mental capacity assessment was undertaken. If assessed as not having capacity to make certain decisions the service followed the guidance under the MCA. Where appropriate the service had made referrals to the local authority to authorise a DoLS. Where people had awarded power of attorney to another person, the service ensured they received a copy of the legal paperwork. We saw that people or relatives with legal authority consented to care and treatment.

We observed two lunchtime meals. People either ate at a dining table, in their room or in the main lounge areas. The meal times were relaxed and informal. People told us, and we observed, the chef discussing with people what the meal choices of the day were. The kitchen staff kept detailed records of people's food likes and dislikes. Information on allergies was available. Outside the kitchen prompts about allergies were also displayed. We observed staff still asking people how they would like their drink of choice even when a like was recorded. This ensured no assumptions were made. One person advised us that they needed a pureed diet due to some difficulties with swallowing. The meal was presented in an appetising and thoughtful way. The person was informed what the meal was when it was presented, and staff supported them to orientate to where the cutlery was.

Where people were at nutritional risk due to frailty, additional build up foods were available, and support was provided with feeding on a one to one basis. Staff, who supported people with their meal, did so in a calm manner and explained each mouthful.

We observed that drinks and fresh fruit were available for people; we spoke with the kitchen staff about this. They advised us that few people were able to access the drinks, but family members were more likely to access it. Where people spent most of the day in their own room, drinks were also made available through the day.

People's healthcare needs were monitored and any changes in their health or well-being prompted a referral to their GP or other healthcare professionals. On the second day of the inspection we were made aware of a referral to a specialist nursing team. The service also had good communication with the GP practice. All decisions regarding health decisions made by the GP were recorded and kept in the care plan file. Where a change in medicine was recommended, we were able to trace when this visit was undertaken and what actions had been undertaken. A full record of visits by healthcare professionals was available in the care plan file.

Good

Is the service caring?

Our findings

People told us that they were happy living at Mandeville Grange. Comments included "I quite like it here," "The staff are nice," and" The staff are marvellous." One relative told us "I cannot think of anything that I am disappointed about," another relative told us "The staff are friendly and caring."

We observed interactions between staff and people throughout the course of two days. We overheard staff talking to people in a respectful manner. People looked relaxed and comfortable in the company of staff. One person told us "I don't know what I would have done without all the support from the staff." Another person said "staff are really good to me, I am very happy with the care they [staff] give me."

Staff we spoke with were able to tell us about how they maintain people's dignity; we observed complex manual handling being carried out in communal areas. This was conducted in a way that was professional and dignified. Staff spoke with the person throughout the transfer.

We observed staff offered choices to people. For instance one person who was escorted in a lounge area was asked where they would like to sit. Another person was asked what activity they wanted to do.

Staff showed concern for people's wellbeing in a caring and meaningful way, and they responded to their needs quickly. For instance when someone was struggling with eating their meal, staff immediately offered support. However they did not take over and acted in a supportive manner.

The service had two main lounge areas downstairs, but also had a snug lounge where people could go and have a quieter time.

One relative informed us they had been able to celebrate a milestone anniversary with their relative who was a resident of the service. They advised "X is very content here, it is home and I come every day and feel welcome."

We observed that rooms had been personalised and that generally doors were shut. However one room off the lobby area which everyone entering the service walked past had its door open. We observed that the person could be seen in their bed. We spoke with the registered manager about this. They agreed that they would ensure they evidenced the person had fully consented to this.

At the time of our inspection the home had advocate involvement for one person. Advocates are independent and represent the person's interests, supporting them to speak or speaks on their behalf to ensure their needs and wishes are taken into account.

People and their relatives were given support when making decisions about their preferences for end of life care. Where necessary, people and staff were supported by palliative care specialists. Services and equipment were provided as and when needed. The service worked with the GP practice to develop an 'end of life care plan'. We saw evidence that this was discussed with the person and where another person had

legal authority for welfare decisions this was discussed with them. The end of life care plan detailed religious beliefs; one person had information about their particular religion and funeral plan for that religion.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to changes in need. Pre-admission assessments were completed by a senior member of staff. The pre-admission assessment covered a wide range of a person health, life and wellbeing. Topics included consideration to first language, sexuality and religious belief. The registered manager had a very clear process for following up new enquiries for vacancies. Everyone who moved into the home was visited prior to a decision being made. The registered manager told us this was to ensure the service could meet the individual needs.

Care plans were present for each person on an individual basis. For people who had particular conditions, additional information was collected about that condition. For instance one person was living with dementia. The care plan contained information on the stages of the illness. The care plans were written in a person centred way. Where people were prescribed medicine, information was available for staff on why the medicine had been prescribed and how it should be administered.

Care practices followed care plans. For instance one person required a pureed diet, this was provided. Another person required a hoist for all transfers; we observed this was being undertaken by staff when assisting the person to move from wheelchair to armchair. One person told us they have a weekly meeting with a senior member of staff to check that the service is meeting their needs.

The service employed an activities co-ordinator. Information about people's interests was gained post admission. An activities scheduled was displayed on notice boards along with 'dates for your diary' and 'themes for religious service in residential care'. We observed an exercise session on day one of our inspection. The session provided an educational theme, as information about muscle strength was being shared. The activities co-ordinator was able to offer group direction and individual direction if needed. People we spoke with who chose to spend most of the day in their room, also had access to activities. One person told us "Y visits daily and we do the crossword together." The activities co-ordinator also visited people who were cared for in bed. This meant that everyone who wished to had access to a meaningful activity.

People were encouraged to continue to participate in activities they enjoyed prior to moving into the home. We observed people reading the daily paper, or using their iPad. Other people told us they enjoyed puzzles. A small library of books was available for people in the conservatory area.

Staff were responsive when people asked for something. One person asked for a drink and this was immediately responded to. Call buzzers were answered swiftly; this was supported by what people told us. One person said, "If I press the call bell at night they (staff) come."

Handover between staff at the start of each shift ensured that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored. Each staff member was allocated a number of tasks at the beginning of the each shift. The senior staff on duty were able to re-prioritise this if any change in people's level of need was noted.

We saw that one person was being supported with treatment for leg ulcers. The care plan was detailed with actions necessary. We saw that photographs were taken to monitor the progress of the skin condition. We spoke with nursing staff and they advised us that referrals to specialist staff are completed when needed. A healthcare professional we spoke with told us that staff make appropriate referrals and the team were very responsive when advice or a treatment plan are put in place.

The service had a complaints procedure, which was clearly displayed in the lobby area. We looked at the complaints log. There were very few made. Where complaints had been made, we saw they had been responded to appropriately by the registered manager. People and their relatives stated that although they did not have any concerns to report. They would know who to speak to and had confidence that it would be taken seriously.

The service worked well with the GP service to prevent unnecessary admission into hospital. The service had a telephone number of a service that also supported people living in nursing homes to avoid admission to hospital. One healthcare professional we spoke with, spoke highly of the teamwork among the staff at Mandeville Grange.

Good

Is the service well-led?

Our findings

People were supported by a service that was well-led. The provider and registered manager had a clear vision to provide a high quality, individualised service. Staff members we spoke with understood this vision. Our observations throughout the two days of inspection showed that people were supported in a person centred way.

The registered manager provided strong leadership, with a clear open door policy. They demonstrated a commitment to development in their own skills and those of the staff. For instance additional training was offered to staff whose first language was not English. Staff we spoke with stated they would not hesitate to raise a concern with the registered manager. One staff member told us "I have not had a reason to raise an issue, but I would have the confidence to if needed." Another staff member said "I feel very supported by management, they have invested in me." The registered manager had an honest and reflective approach to their role.

Where staff had issues that affected their role, additional support was offered. Sometimes this was through referrals to counselling services, or workplace policies. This helped staff understand their own role and expectations on them.

Meetings were held with staff and the provider also attended these on occasions. Minutes of these meetings demonstrated that communication was two way and respectful to each role within the home. The service had a variety of policies in place to assist with the running of the home; these included safeguarding people, infection control and equal opportunities.

The registered manager advised that quality assurance systems were in place to monitor the quality of service being delivered and the running of the home. This included supervision of staff when undertaking personal care and support. This provided an opportunity to monitor safety and skills of care staff. In addition to this the service used satisfaction surveys to help capture the quality of the service. Questionnaires were sent to residents, staff, family and relatives. The results from these surveys were gathered and analysed. The provider visited undertook checks of the service on a regular basis. Records of these checks were made, and action plans were developed. There was evidence that actions required by the registered manager had been completed.

The registered manager used a quality improvement self-assessment record. These audits included an infection control audit and audit of accidents and incidents. This helped them concentrate on the areas of improvement to be made.

The service engaged with outside agencies to monitor their performance. In the last twelve months the service had visits from the Environmental health team who rated the kitchen facilities as a standard 4 out of 5. It had engaged in a dignity survey by Healthwatch and the local authority had conducted a contract monitoring visit in April 2015. The service had been invited to join a project carried out by the clinical trials team at Kings College, London on age-related diseases. The registered manager advised they were keen to

accept the offer, but informed us that consent had not been gained from people living in the service yet.

The registered manager had notified CQC about significant events. We used this information to monitor the service and ensure they responded appropriately to keep people safe. For instance we had received information when a safeguarding referral had been made to the local authority

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure that it stored controlled medicines in a safe way. More stock was stored than required. Regulation 12 (2) (g)