SVP Health Care Limited

# The Old Vicarage Care Home

## Inspection report

2 Waterville Road
North Shields
Tyne and Wear
NE29 6SL

Tel: 01912570937

Date of inspection visit:
21 March 2018

Date of publication:
21 June 2018

## 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? | Requires Improvement |
| Is the service well-led? | Good |

# Summary of findings

## Overall summary

This was an unannounced inspection which we carried out on 21 March 2018. We inspected the service to follow up on the breaches and to carry out a comprehensive inspection.

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

The Old Vicarage is registered to provide accommodation and personal care to a maximum of 36 older people, including people who live with dementia.

We last inspected The Old Vicarage in December 2016. At that inspection we found the service was in breach of its legal requirements with regard to Regulation 11 and Regulation 17 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve to at least good in the areas identified. These included with regard to where people lacked capacity to consent the provider had not always acted in accordance with the Mental Capacity Act 20015. Robust quality assurance systems were not in place and records did not provide an accurate account of the care people received.

At this inspection we found improvements had been made so the service was no longer in breach of its legal requirements. Staff had an understanding of the Mental Capacity Act 2005 and best interest decision making, when people were unable to make decisions themselves. Records were in place that reflected people's care and support requirements and they were regularly reviewed to ensure they remained accurate. The home had a more effective quality assurance programme to check the quality of care provided.

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 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.

Due to their health conditions and complex needs not all people were able to share their views about the service they received.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible, the policies and systems in the service supported this practice.

People and staff told us they felt safe and there were enough staff on duty to provide safe and individual

care to people. People were protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse. When new staff were appointed, thorough vetting checks were carried out to make sure they were suitable to work with people who needed care and support.

Risk assessments were in place and they identified current risks to the person. Staff knew the people they were supporting well.

People said staff were kind and caring. Limited activities and entertainment were available to keep people engaged and stimulated. We saw staff did not always interact and talk with people. We have made a recommendation about training about person-centred care.

Appropriate training was provided and staff were supervised and supported.

People received a varied and balanced diet to meet their nutritional needs. People had access to health care professionals to make sure they received appropriate care and treatment. Staff followed advice given by professionals to make sure people received the care they needed. Systems were in place for people to receive their medicines in a safe way.

A complaints procedure was available. Staff and relatives said the management team were approachable. People had the opportunity to give their views about the service. There was consultation with people and family members and their views were used to improve the service. People had access to an advocate if required.

## 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.

People were kept safe as systems were in place to ensure their safety and well-being. Regular checks were carried out to ensure the building was clean, safe and fit for purpose. Risk assessments were up-to-date and identified current risks to people's health and safety. People received their medicines in a safe way.

Staffing levels were sufficient to meet people's current needs safely. Appropriate checks were carried out before new staff began working with people.

Staff had received training with regard to safeguarding. People were protected from abuse and avoidable harm.

### Is the service effective?

Good

The service was effective.

Staff received the training they needed and regular supervision and appraisals.

People's rights were protected. Best interest decisions were made on behalf of people, when they were unable to give consent to their care and treatment.

Effective communication ensured the necessary information was passed between staff to make sure people received appropriate care. Staff liaised with General Practitioners and other professionals to make sure people's care and treatment needs were met.

People received food and drink to meet their needs and support was provided for people with specialist nutritional needs.

### Is the service caring?

Good

The service was caring.

Staff were caring and respectful. People and their relatives said the staff team were compassionate, kind and cheerful.

Staff were aware of people's backgrounds and personalities. Good relationships existed and staff were aware of people's needs and met these in a sensitive way that respected people's privacy and dignity.

People had access to an advocate if required.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

There was a good standard of record keeping. Staff were knowledgeable about people's needs and wishes.

Staff in some areas of the home did not engage and interact with people except when they provided care and support. There were limited activities and entertainment available for some people.

People had information to help them complain. Complaints and any action taken were recorded.

## Is the service well-led?

**Good**

The service was well-led.

A registered manager was in place. Staff and relatives told us the management team were available to give advice and support.

Staff informed us that they enjoyed working at The Old Vicarage and they worked as a team.

The home had a quality assurance programme to check on the quality of care provided.

# The Old Vicarage 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 21 March 2018 and was unannounced. The inspection was carried out by one adult social care inspector.

Before the inspection we reviewed information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are reports of changes, events or incidents the provider is legally obliged to send CQC within required timescales. We contacted commissioners from the local authorities who contracted people's care and other professionals who could comment about people's care.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us.

We undertook general observations in communal areas and during mealtimes.

During the inspection we spoke with five people who lived at the Old Vicarage, the registered manager, the deputy manager, three relatives, the cook, three support workers, one team leader and two visiting professionals. We observed care and support in communal areas and looked in the kitchen. We reviewed a range of records about people's care and how the home was managed. We looked at care records for four people, recruitment, training and induction records for four staff, four people's medicines records, staffing rosters, staff meeting minutes, meeting minutes for people who used the service, the maintenance book,

maintenance contracts and quality assurance audits the registered manager had completed.

Good

# Is the service safe?

## Our findings

People who used the service and relatives expressed the view that they and their relatives were safe at the home. One relative commented, "[Name] is quite settled here." Another relative told us, "I think people are kept safe, there is always a staff member nearby or in the lounge."

There were 29 people living at the home at the time of inspection. The registered manager told us staffing levels were determined by a dependency tool. This was used to check against each person's dependency profile to calculate if there were sufficient staff to meet people's needs safely. Staffing rosters and our observations showed five support staff were on duty between 8:00am and 8:00pm. These numbers did not include the registered manager and deputy manager who were on duty during the day and available on call overnight. We considered there were enough staff on duty to meet people's needs.

People's individual risk assessments were in place with a system of review to ensure they remained relevant, reduced risk and kept people safe. The risk assessments included risks specific to the person such as for moving and assisting, mobility, choking, nutrition and pressure area care. The monthly evaluations included information about the person's current situation. Environmental risk assessments such as for the use of oxygen, fire, falls from windows and the kitchen environment were in place with a regular monthly review to ensure they remained accurate and reflected any current risk around the home.

Regular monthly analysis of individual incidents and accidents took place. Learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of them recurring. For example, with regard to people who may be at risk of falls. Records showed people were referred to the relevant professional for advice and guidance when a certain amount of incidents were recorded.

The home was clean, tidy and with no unpleasant smells. Infection control procedures were in place. Staff had access to personal protective equipment (PPE) to reduce the risk of the spread of infection.

A personal emergency evacuation plan (PEEP) was available for each person taking into account their mobility and moving and assisting needs. The plan was reviewed regularly to ensure it was up to date. This was for if the building needed to be evacuated in an emergency.

We saw from records that the provider had arrangements in place for the on-going maintenance of the building and a maintenance person was employed. Routine safety checks and repairs were carried out, such as for checking the fire alarm and water temperatures. Regular fire drills were carried out and fire instructions and training with staff to inform them of action to take in the event of a fire. External contractors carried out regular inspections and servicing, for example, fire safety equipment, electrical installations and gas appliances. There were records in place to report any repairs that were required and this showed that these were dealt with. We also saw records to show that equipment used at the home was regularly checked and serviced, for example, the passenger lift, hoists and specialist baths.

Staff were clear about the procedures they would follow should they suspect abuse. They were able to

explain the steps they would take to report such concerns if they arose. They expressed confidence that allegations and concerns would be handled appropriately by the registered manager. They informed us they had received recent relevant training. One staff member told us "I'd speak to my manager about any concerns." Another commented "I've done safeguarding training."

The registered manager understood their role and responsibilities with regard to safeguarding and notifying the Care Quality Commission (CQC) of notifiable incidents. They had ensured that notifiable incidents were reported to the appropriate authorities and independent investigations were carried out if necessary. We viewed the safeguarding records and found concerns had been logged and raised appropriately by the registered manager. They had been investigated by the provider where required and the necessary action had been taken by the provider to address the concerns. The information had been shared with other agencies for example, the local authority safeguarding team. We were told learning took place from safeguarding incidents.

Medicines were given as prescribed. We observed part of a medicines round. We saw staff who were responsible for administering medicines checked people's medicines on the medicine administration records (MARs) and medicine labels to ensure people were receiving the correct medicine. Staff who administered the medicines explained to people what medicine they were taking and why. People were offered a drink to take with their tablets and the staff remained with the person to ensure they had swallowed their medicines. Medicines records were accurate and supported the safe administration of medicines. There were no gaps in signatures and all medicines were signed for after administration.

We spoke with members of staff and looked at personnel files to make sure staff had been appropriately recruited. We saw relevant references and a result from the Disclosure and Barring Service (DBS) which checks if people have any criminal convictions, had been obtained before they were offered their job. Application forms included full employment histories.

Good

# Is the service effective?

## Our findings

At the last inspection we had concerns that some best interests decision making, where people did not have mental capacity, had not always been appropriately made and records for some best interest decision making, did not reflect the Mental Capacity Act 20015 guidance. At this inspection we found improvements had been made and the service was no longer in breach of this requirement.

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

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw that all DoLS applications were clearly documented and stored and that where people were being restricted then this was done so in their best interests and the least restrictive option was always considered. We observed staff demonstrated a sound understanding of their duty to promote and uphold people's human rights. The registered manager had submitted DoLS applications appropriately and told us 15 authorisations were in place and three applications had been submitted for processing by the local authority.

Records showed that assessments were now carried out to check people's capacity and understanding with regard to specific decisions. For example, for the use of bedrails. They also recorded who was involved in the decision making process where decisions were made in people's best interests.

Assessments were carried out to identify people's support needs and they included information about their medical conditions, dietary requirements and their daily lives.

Staff told us when they began working at the service they had completed an induction programme and had an opportunity to shadow a more experienced member of staff. This ensured they had the basic knowledge needed to begin work. They said training consisted of a mixture of face to face and practical training. The registered manager told us all staff undertook the Skills for Care, Care Certificate to further increase their skills and knowledge in how to support people with their care needs. (The Care Certificate was introduced in April 2015 and is a standardised approach to training for new staff working in health and social care.)

Staff made positive comments about the support they received and training attended. One staff member commented, "We get lots of training, usually monthly." Another member of staff said, "There are opportunities for personal development." Other staff member's comments included, "We have supervision every two-three months" and "There's loads of training."

The staff training matrix showed staff were kept up-to-date with safe working practices. The staff training records showed and the manager told us there was an on- going training programme in place to make sure staff had the skills and knowledge to support people. Training courses included equality and diversity, dementia care, nutrition, positive behaviour support, dignity in care, people's meal time experience, mental capacity and risk taking.

People were supported to maintain their healthcare needs. A visiting health care professional told us, "Staff are very good at letting me know if they have any concerns." Another visiting professional commented, "Communication is really effective with staff at the home." People's care records showed they had regular input from a range of health professionals such as, General Practitioners (GPs), district nurses, psychiatrists, dietician and a speech and language team (SALT). Records were kept of visits.

Relatives told us they were kept informed by the staff about their family member's health and the care they received. One relative commented, "They (staff) will telephone to let me know if [Name] is unwell." Another relative told us, "Staff keep me informed about [Name] and let me know what is going on."

Systems were in place to ensure people received varied meals at regular times. We spoke with the cook who was aware of people's different nutritional needs and special diets were catered for. They told us people's dietary requirements such as if they were vegetarian or required a culturally specific diet were checked before admission to ensure they were catered for appropriately. They explained about how people who needed to increase weight and to be strengthened would be offered a fortified diet and they explained how they would be offered milkshakes, butter, cream and full fat milk as part of their diet. People received drinks in between meals and the tea trolley provided a variety of drinks and biscuits. One relative told us, "[Name] has put on weight since they've come to live here, which is a good thing."

People who were at risk of poor nutrition were supported to maintain their nutritional needs. This included monitoring people's weight and recording any incidence of weight loss. Referrals were also made to relevant health care professionals, such as dieticians and speech and language therapists for advice and guidance to help identify the cause. Records were up to date and showed people with nutritional needs were routinely assessed monthly against the risk of poor nutrition using a recognised nutritional screening tool. Care plans were in place that recorded people's food likes and dislikes and any support required to help them to eat.

Food was well presented and looked appetising. People and relatives were positive about the food saying there was enough to eat and they received nice food. One person told us, "The food is okay, there's plenty to eat." Another person said, "We have a variety of meals, they're very tasty." A third person commented, "Staff will ask what we want to eat as there is a choice of meal." A relative told us, "[Name] is given a choice when asked about food."

Good

# Is the service caring?

## Our findings

The atmosphere in the home was calm, friendly and welcoming. People who used the service and relatives we spoke with were positive about the care and support provided. One person commented, "The care is very good here." Another person said, "The staff are very kind." Other people's comments included, "The staff are first class", "There are no problems with the staff." One relative told us, "The staff are lovely." Another relative said, "[Name] is comfortable and well-looked after." Other relative's comments included, "Everyone's very friendly here" and "All staff are very approachable."

People told us they made their own choices over their daily lifestyle. They told us they were able to decide for example, when to get up and go to bed and what they might like to do. One person told us, "I like to go to my room to watch television before supper." Another person said, "I enjoy a lie-in in the morning." Staff described how they supported people who did not express their views verbally. They gave examples of asking families for information, showing people options to help them make a choice such as showing two items of clothing. This encouraged the person to maintain some involvement and control in their care. Staff also observed facial expressions and looked for signs of discomfort when people were unable to say for example, if they were in pain.

However, we considered some improvements were needed to keep people involved in daily decision making. We observed on the middle floor some staff did not ask people what they wanted to drink at the mid-morning drink time. They prepared and served drinks to people without asking them. They did not interact with the person other than to say, "There's a drink of tea." Information advertising menus and activities was not displayed in an accessible format to help people make a choice if they did not read. We discussed this with the registered manager who told us it would be addressed.

People's care records were up-to-date and personal to the individual. They contained information about people's likes, dislikes and preferred routines. Examples included, '[Name] prefers a bath sometimes with bubbles. Would like staff to ask first, prefers a bath after tea.' Staff were knowledgeable about the people they supported. They were aware of their preferences and interests, as well as their health and support needs.

Support plans provided detailed information to inform staff how a person communicated or made decisions. For example, one communication support plan stated, '[Name] can communicate their choices including with very minimal or irregular communication.' Another recorded, '[Name] is able to make day-to-day decisions.'

People appeared relaxed with staff. Staff interacted in a caring and patient manner with people. They acted with professionalism and compassion. When staff carried out tasks with the person they bent down as they talked to them so they were at eye level. They explained what they were doing as they assisted people and they met their needs in a sensitive and sympathetic manner.

People's privacy and dignity were respected. People told us staff were respectful. We observed that people

looked clean, tidy and well presented. We observed staff knocked on people's doors before entering their rooms, including those who had open doors.

We observed the lunch time meals in the dining rooms. We saw the meal time was relaxed and unhurried. People sat at tables that were set with tablecloths. Specialist equipment such as cutlery and plate guards were available to help people, who were able to maintain some independence as they ate their food. A choice of drinks was available. The meals looked and smelled appetising and generous portions were available. Staff provided full assistance or prompts to some people to encourage them to eat, and they did this in a quiet, gentle way and explained to people what they were getting to eat with each spoonful. Staff talked to people as they helped them and as lunch was served.

There was information displayed in the home about advocacy services and how to contact them. The registered manager told us people had the involvement of an advocate, where there was no relative involvement. Advocates can represent the views for people who are not able to express their wishes.

Requires Improvement

# Is the service responsive?

## Our findings

We found that the breach of regulation and areas for improvement identified at the last inspection had been acted upon. At this inspection we found improvements had been made to record keeping and the service was no longer in breach of this requirement. However, we considered improvements were required with regard to activities to keep people engaged and stimulated.

There was a good standard of record keeping to help ensure people's needs were met individually. Detailed information was available so staff were aware of people's like, dislikes and how they wished their care to be provided when they may no longer communicate their wishes verbally.

The registered manager told us an electronic system was being introduced and all records were being transferred to this system. Staff were to receive training about using the system.

Before people used the service they received information about the home and an initial assessment was completed to ensure the service could meet the person's needs. Care plans were developed from assessments that provided some details for staff about how the person's care needs were to be met. Records showed that monthly assessments of peoples' needs took place with evidence of evaluation that reflected any changes that had taken place. For example, with regard to nutrition, mobility, falls and personal hygiene. Evaluations included information about people's progress and well-being. Reviews of peoples' care and support needs took place with relevant people.

Care plans provided information for staff about how people liked to be supported. For example, a care plan for personal hygiene stated, '[Name] likes a bath at least once a week supported by two staff members.' Other information was available in people's care records to help staff provide care and support. For example, '[Name] to eat little and often. Staff to offer snacks in between meals' and '[Name likes to go to bed between 8:00 pm and 9:00 pm.'

Staff completed a daily diary for each person and recorded their daily routine and progress in order to monitor their health and well-being. This information was then transferred to people's support plans which were up-dated monthly. Charts were also completed to record any staff intervention with a person. For example, for recording the food and fluid intake of some people and when personal hygiene was attended to and other interventions to ensure peoples' daily routines were met. These records were used to make sure staff had information that was accurate so people could be supported in line with their up-to-date needs.

Records showed the relevant people were involved in decisions about a person's end of life care choices when they could no longer make the decision for themselves. Care plans detailed the 'do not attempt cardio pulmonary resuscitation' (DNACPR) directive that was in place for some people. We were told this was discussed and the relevant people were involved in the decision making to inform staff of the person's wishes at this important time and to ensure their final wishes could be met.

People and relatives confirmed there was a choice of activities available. One person told us, "We have a tea afternoon." One relative commented, "There's a fund-raising committee and a sensory garden is planned." Another relative told us, "People like bingo." A third relative said, "Activities tend to be in the afternoon."

An activities person was employed. They were not on duty on the day of inspection although a movie afternoon took place with an outside entertainer. An activities programme advertised armchair exercises, dominoes, music, singing, pamper days and hairdresser. We discussed with the registered manager the need to ensure people were provided with opportunities for engagement and activities to keep them stimulated at any time and not just when the activities person was on duty. The deputy manager told us there were opportunities to go out on organised trips and these included visits to the town centre, coast and places of interest.

From our observations we considered improvements were needed to ensure that all staff interacted with people at all times, and not only when they carried out care and support with the person. Staff told us mornings were busy. On the middle floor staff engaged with people at mealtimes and when the drinks trolley came around or when people were assisted with personal care. We did not observe staff take the opportunity to engage and interact with each person and encourage their awareness and interest in their surroundings. In the morning we saw several people sat sleeping in the lounges in front of a television and there was nothing of interest to keep them engaged and stimulated when staff were busy. For example, rummage boxes and items for reminiscence were not available for people who lived with dementia. Newspapers, books, magazines, jigsaws, quiz books were not available to keep people involved and orientated. We discussed this with the registered manager who told us it would be addressed.

We recommend that staff receive training about person-centred care and personhood to ensure that people who live with dementia are kept engaged and stimulated and offered meaningful activities if they wish to take part.

We observed people were more engaged in the afternoon and staff spent time sitting with people and talking to them. They offered people a choice of activities and arranged them in small groups or individually.

People knew how to complain. People we spoke with said they had no complaints. A relative commented, "I know who to speak to if I needed to complain." The complaints procedure was on display in the entrance to the home. A record of complaints was maintained and a complaints procedure was in place to ensure they were appropriately investigated.

Good

# Is the service well-led?

## Our findings

A registered manager was in post who had registered with the Care Quality Commission in February 2016. 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.

We found that the breach of regulation and areas for improvement identified at the last inspection had been acted upon. At this inspection we found improvements had been made and the service was no longer in breach of this requirement.

Robust auditing and governance processes now took place within the service to check the quality of care provided and to keep people safe.

A quality assurance programme included daily, weekly, monthly and quarterly audits. Audits included checks on the environment, finances, medicines management, care documentation, training, kitchen audits, accidents and incidents, infection control and nutrition.

All audits showed the action that had been taken as a result of previous audits. A risk monitoring report that included areas of care such as safeguarding, complaints, infection control, pressure area care and serious changes in a person's health status was completed by the home and passed to the office for analysis.

Monthly audits included checks on care documentation, people's dining experience, staff training, medicines management, home presentation, complaints management, health and safety and accidents and incidents. Other audits included for health and safety and infection control. Other audits were carried out for falls and health and safety. Monthly visits were carried out by the provider's representative who would speak to people and the staff regarding the standards in the home.

The registered manager and deputy manager assisted us with the inspection. Records we requested were produced promptly and we were able to access the care records we required. The registered manager and staff were open to working with us in a co-operative and transparent way.

The atmosphere in the service was warm, welcoming and open. A variety of information with regard to the running of the service was displayed to keep people informed and aware and this included the complaints procedure, safeguarding, advocacy and forthcoming events.

The registered manager was enthusiastic and had introduced ideas to promote the well-being of people who used the service. Staff and people we spoke with were all very positive about their management and had respect for them. They told us the service was well led. They said they could speak to the manager if they had any issues or concerns. One staff member told us, "The management are very approachable." A relative commented, "A very approachable manager."

People and their relatives were kept involved and consulted about the running of the service. Regular meetings took place with relatives and people who used the service and minutes were available for people who were unable to attend. One relative told us, "We have social fund committee meetings to discuss fund raising events."

Staff told us and meeting minutes showed staff meetings took place. Meetings kept staff updated with any changes in the service and allowed them to discuss any issues. One staff member commented, "Staff meetings happen two monthly." Another staff member told us, "Senior staff have a monthly meeting."

Staff said communication was effective within the home. A handover session took place, between senior staff, to discuss people's needs when staff changed duty, at the beginning and end of each shift. One staff member told us "Communication is effective." Another staff member said, "We have a handover when we come on duty to find out how people are." Staff told us the diary and communication book also provided them with information.

The provider monitored the quality of service provision through information collected from comments, compliments/complaints and survey questionnaires that were sent out annually to people who used the service and relatives. Staff, people and relative's comments that were made during the inspection were overwhelmingly positive. Relative's comments included, "I'd definitely recommend the home" and "Everything is fine." Staff comments included, "I love working here" and "There's a good team structure."