Care Quality Commission

Mr M J Volf & Mrs J L Volf

Mistley Manor

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?	**Requires improvement**
Is the service well-led?	**Inadequate**

Overall summary

This inspection took place on 20 October 2015 and was unannounced.

Mistley Manor is registered to provide accommodation and personal care for up to 66 people. On the day of our inspection there were 39 people living in the service. The accommodation is located over three floors. The third floor had four suites which could accommodate two people in each. The service had an onsite licensed bar and cinema.

The service had two registered managers. 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.

The requirements of the Deprivation of Liberty Safeguards were not being met. Mental capacity assessments were generic with the same wording used in several assessments. They were not specific to the person and the decision and did not reflect that a person's capacity to make a decision may fluctuate. The use of restraint was not recorded and monitored according to the services' own policy.

Summary of findings

The service did not have a system to monitor staffing levels and people's views varied as to whether staffing numbers were sufficient with most feeling that these were not enough staff at particular times of the day.

Medicines were stored and administered safely. However, some people did not get them at their preferred time of day or when they were required.

A choice of food and drink was available that reflected people's nutritional needs and took into account their personal preferences or health care needs.

People and staff had developed positive, caring relationships. People felt they were looked after by kind, friendly staff who knew them well.

Records showed that staff had received training in to perform their role. However, we found that the training records was not accurate. Staff participated in an induction programme and shadowed senior staff before providing care.

People did not feel that they had been involved with their care planning. Care plans covered people's care needs. Risks to people had been identified and assessed. However, some risk assessments were generic and did not reflect the individual circumstances of the person.

People were not provided with support to continue with activities they may have enjoyed before moving into the service. Facilities available to people within the service such as a library and cinema were not always fully exploited.

Records kept by the service in relation to the running of the service were not always accurate. The management team did not carry out regular quality assurance and audits of the service to check the quality of care people received and drive improvement.

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?

Requires improvement

The service was not consistently safe.

Procedures for reporting the use of restraint were not followed.

Risks to people were assessed but some risk assessments were generic and may not reflect the needs of the individual.

Medicines were managed and administered safely. People did not always receive their medicine at the time they preferred and needed.

There was no process in place to ensure there were sufficient staff available to meet people's needs throughout the day.

People felt safe in the service and staff were aware of the processes involved in safeguarding adults from harm.

Is the service effective?

Requires improvement

The service was not consistently effective.

The requirements of the Deprivation of Liberty Safeguards were not met.

People were provided with a varied and nutritious diet in line with the personal preferences and need.

Is the service caring?

Good

The service was caring.

People made positive comments about the caring and kind approach of the staff.

Staff respected people's right to privacy and dignity.

People were encouraged to express their views.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

People were not involved in their care planning.

Access to social activities both within the service and outside was limited.

People knew how to complain and were confident that any complaints would be listened to and acted upon.

Is the service well-led?

Inadequate

The service was not well-led

Systems were not in place to monitor the quality of the service provided.

Summary of findings

The management team had not put systems in place to drive improvement and improve the quality of the service.

Mistley Manor

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 20 October 2015 and was unannounced.

The inspection team consisted of one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience had expertise in caring for an older person.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we held about this service. This information included information about certain events which providers are required to notify us about.

During the inspection, we used a number of different methods to help us understand the experiences of people who lived in the service. We spoke with the two registered managers, the cook, five care staff, seven people living in the service, three relatives and a visiting care professional.

We also looked at a range of records including four people's care plans, four staff recruitment files, staff training records, medicines administration records and a sample of policies and procedures and quality assurance records.

Requires improvement

Is the service safe?

Our findings

All people spoken with told us they felt safe and secure living in the service. One person said, "I feel much safer here than when I was living at home." Another person said, "I can sleep at night totally reassured." Similarly relatives spoken with expressed satisfaction with the service and told us they had no concerns about the safety of their family member. One relative said, "They come in regularly to see [person] is alright."

We discussed safeguarding vulnerable adults with the staff. All said if there was anything that caused them concern they would speak with a senior member of staff or one of the registered managers. However, two members of staff said they had not received training in safeguarding adults since they had begun working for the service approximately six months previously. We queried this with one of the registered managers who advised that they had checked their records and had found that one staff member had been recorded as completing the training when they had not. Staff who have not received training in protecting adults from abuse may not know what constitutes abuse and the correct procedures for reporting this.

For a person living with dementia we saw an accident report where the person had been physically restrained. We requested the service's policy on restraint. This was not immediately available but was printed from the computer by a registered manager. The policy clearly stated that following an incident where restraint was used a 'Planned/ Unplanned Restrictive Intervention Form' should be completed and that an emergency care review must be held within three days. We asked both managers if these actions had been taken following this incident. They confirmed they had not and displayed no knowledge of the form their policy required them to use. Inadequate recording and monitoring of this type of intervention may lead to its inappropriate use and the person not receiving other appropriate interventions.

We found individual risks had been assessed and recorded in people's care plans and management strategies had been drawn up to provide staff with guidance on how to manage risk in a consistent manner. Examples of risk assessments included receiving personal care, moving and handling, nutrition and hydration and specific risk encountered by individuals. However, a number of these risk assessments were generic and were not specific to the person. For example, the wording in the risk assessments for bathing and showering was the same. Risk assessments written in this way may not reflect an individual's needs and staff may not address an individual's needs but treat all in the same way.

People held mixed views as to whether there were sufficient staff. One person said, "Asking for something can take ages," another said, "I find they stay for a while, they're terribly busy, then off they go," and another said, "It's always a rush." People told us that staff levels varied according to the time of day. One person said, "No, it's very difficult to find a helper after the evening meal." However, a visiting relative said, "That's what I like about it here, staff come round and they can sit and talk to you."

Staff told us that they felt there were sufficient staff on duty to provide people with the care required. One member of staff told us, "Yes, enough staff." They went on to explain that if they were short staffed a member of the management team was able to provide care. Another member of staff told us that they had time to get to know people personally.

The registered managers told us that they did not have a formal method to ensure that there were sufficient staff on duty to meet people's needs throughout the day. They went on to say that staffing levels were monitored on an informal basis. Monitoring of staffing levels against the needs of the people using the service would mean that the service could ensure that sufficient staff were available throughout the day to meet people's needs.

The service followed safe recruitment practices. We looked at four recruitment files for staff employed by the service and noted appropriate checks had been carried out to ensure staff were suitable to work in this type of service before the staff members started work.

People demonstrated a knowledge of the medicines they were taking. Regarding receiving their medicines one person said, "It mostly goes swimmingly." However, another person said, "Yes, I've been taking them for years." However, they went on to say, "I don't get them when I should have them, last night it was very late, quarter past nine, normally seven fifteen." Another person said, "They didn't come until eleven, sometimes I'm in bed by ten fifteen." Another person explained how the late administration of their medicines meant they could not have their breakfast until late as they required a specific amount of time between

Requires improvement

Is the service safe?

taking their medicines and eating food. We asked the registered managers about this who had not noted it as a problem but said they would address the issue. The late administration of medicines could be reflective of insufficient staff to meet people's needs as mentioned in previous paragraphs.

There were safe systems for the storage and recording of medicines. Medicines were stored securely in a locked room. Medicines received into the service were recorded when received and administered or refused. This gave a clear audit trail and enable staff to know what medicines people had taken. Staff had received training to administer people's medicines safely.

Requires improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken.

Staff had received training in the application of the MCA and DoLS. We observed staff putting the principles of the MCA into practice. For example we saw one person living with dementia refusing to move from the dining table. A member of staff spent time talking to them and explaining their choices in way they could understand. They agreed to move to a more comfortable chair. Another member of staff said, "We help them to choose their own clothing and take time to explain what's being done. Some people can still make their own choices and we encourage that."

The service was not implementing DoLS. The first floor of the service was locked with key pads. People did not have the number to the key pads and it was not accessible to them. A number of people on this floor were subject to continuous supervision and were not free to leave. One person's care plan described how if they went to the front door they must be supervised as they had previously tried to leave the service unsupervised. Another person's care plan recorded that '[Person] is always expressing the need to "get out of here". [Person] can be come fixated with trying to get out of the doors and use lift to escape.' The service had not applied to the appropriate authorities for a DoLS authorisation as required.

Mental capacity assessments had been carried out for a variety of activities. However, these were generic in wording and not specific to individual decisions by individual people. Neither did they address that a person's condition may mean that their capacity to make decisions could fluctuate and there may be times when a person is better able to make a decision.

This was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People received care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. People were happy with the care they received and told us that it met their needs. One person said, "Do you know there isn't one person [staff] here that I can find fault with, they're all very, very good."

Staff told us they had received induction training and shadowed a more experienced member of staff when they first joined the service. They told us they had received training in first aid, manual handling, food hygiene and subjects relevant to individual people's needs such as epilepsy. Records we saw confirmed this. Staff spoken with enthusiastically described recent dementia training they had received which simulated some of the challenges encountered by people living with dementia.

The management team told us that most training was provided by in-house trainers. They said trainers kept their knowledge up to date with support from a local training organisation which specialised in providing training for the care sector.

Staff told us they were provided with regular supervision and were supported by the management team. The supervision sessions enabled staff to discuss their performance and provided an opportunity to discuss any issues relevant to their performance and development.

People were supported to have sufficient amounts to eat and drink and maintain a balanced diet. People told us they enjoyed the food and were given a choice of meals and drinks. One person said, "Yes, the food is very good, two choices and the chef is pretty good with cakes and crumbles." Refreshments and snacks were observed being offered throughout the day. We saw a member of staff asking a person if they would like the fruit bowl in their bedroom topping up. They told us, "They're not just doing that because you're here."

People's dietary needs had been assessed and where appropriate referrals to a dietician or GP had been made. Where people had been identified as at risk of not eating or drinking sufficient to maintain good health action had been taken to address this.

Weekly menus were planned and rotated every four weeks. The chef told us that there were plans to introduce a seasonal menu. People could choose where they liked to eat, some in their bedrooms, others in the dining areas. We

Requires improvement

Is the service effective?

observed the lunchtime period. The tables in the dining areas were dressed with place settings, tablecloths and condiments. Staff supported people appropriately and people were able to enjoy their meal at their own pace.

There were systems in place to communicate people's dietary needs and requirements to the catering staff. The cook spoke with was committed to providing people with good quality food in line with their preferences. They said, "If it's in the kitchen you can have it."

People were supported to maintain good health. Records showed that people were registered with a GP and received care and support from other professionals such as the district nurse and chiropodist.. One person said, "They [staff] suggested seeing the GP without being asked." Another said, "I saw the chiropodist yesterday, they come every six weeks.

Good

Is the service caring?

Our findings

All people spoke with expressed satisfaction with the care provided. One person told us, “It feels that personal, good all round attitude, I think they treat you as though you’re family.” Another person said, “Every one of them [staff] has got endless patience.”

We observed the service had a friendly and welcoming atmosphere. One person told us, “We’re never made to feel that we’re bothering them [staff], they look in to check on us, we never need to ask.” Staff spoken with understood their role in providing people with compassionate care and support. We observed staff providing support to people promptly and unobtrusively.

People were encouraged to express their views as part of daily conversations and residents’ meetings. The residents’ meetings helped keep people informed of proposed events and gave people the opportunity to be consulted and make shared decisions. We saw records of the meetings during our inspection and saw that a variety of topics had been discussed including changes to the menu and the provision of a notice board in the reception area. We saw the new notice board which had ben provided in the reception area and the registered managers told us that changes to the menu had been made.

Staff knew the people they were supporting and took practical action to address concerns. An example of this was where a person living with dementia was noticed to be behaving out of character. The reasons for this were explored which led to the person being diagnosed with a medical condition.

People’s privacy and dignity was respected. People told us that staff respected their right to privacy and always knocked before entering their bedroom. One person told us, “They always knock, they [member of staff] are more of a friend.” When asked about respect and privacy a visiting relative said, “Oh, I definitely do, staff knock and call out, they don’t just come barging in.”

People were supported to be comfortable in their surroundings. People told us they were happy with their bedrooms, which they were able to personalise with their own furniture and possessions. This helped to ensure and promote a sense of comfort and familiarity. We noted there were memory boxes built into the wall outside bedrooms. These included photographs and memorabilia, which had been chosen as something the person related to. For example some people had a photograph of themselves, others had a picture with a family member. This promoted good dementia care and enabled people to orientate themselves so they were not always dependent upon staff.

Relatives spoken with confirmed there were no restrictions placed on visiting and they were made welcome in the service. We observed relatives visiting throughout the day and observed one person eating lunch with their relative. This enabled people to maintain regular contact with their friends and relatives

Requires improvement

Is the service responsive?

Our findings

People using the service told us that they did not contribute to the assessment and planning of their care. One person said, "No I don't, yes it would be very interesting." A visiting relative said they had been asked about their [relative's] history when they first started using the service a number of months ago but nothing since. A relative had responded to the service quality assurance survey with the comment, "I would appreciate the opportunity to have a formal discussion about [relative's] care plan at a convenient time."

Care plans we looked at did not demonstrate that people had been involved with their development and review. The registered manager's told us that an initial assessment was carried out with the person before they began using the service. We looked at the completed assessments which covered all aspects of the person's needs. These had been used as the basis for developing the person's care plans. They did not demonstrate that the person had been involved in their writing or development either with a signature or in the format they were written. For example one care plan stated, 'we have found that……'. This did not demonstrate that the person had been consulted or involved in their care planning. Lack of involvement by people in their care planning could result in people receiving care that was inappropriate or did not meet their preferences.

Some staff we spoke with said they did not always get time to read people's care plans when they moved into the service. They said they got to know what people's needs by, "Going in and introducing myself and getting to know what they need." This is reflected in the comment by one person when speaking about staff said, "Sometimes if there are new ones it takes time." This meant that people may not be provided with care which met their needs.

People were not supported to follow interests and social activities they may have had prior to moving into the service. One person said, "I can't get to a shop to buy talcum powder. I would be happy to just go out for walk." Another person said, "I can't remember the last time I was outside." A third person said, "We want to start living again."

A regular programme of activities or entertainment was not provided to ensure people did not become socially isolated. One person said, "Kenny comes and plays guitar and sings on a Wednesday." Another person said, "We need something to keep us galvanised, there's nothing else that's regular." The registered managers told us that a programme of regular activities was being developed and that they had recently recruited an activities co-ordinator. Until this person was able to begin employment staff were being encouraged to support people with activities they were interested in. We observed a member of staff playing scrabble and another member of staff helping a person to complete a jigsaw puzzle.

The service had a library area where books were available for loan by people living in the service. However, no large print books were available and the registered managers were unable to tell us how much the library was used. In this area there was a computer which the managers told us could be used by people and their visitors. When asked how often this had been used one of the managers told us it had not been used. The service was not fully exploiting the facilities available.

The service had a licensed bar, a hairdressing salon and a cinema. The registered managers told us that they encouraged people's relatives to come in and use the facilities so that visiting their relative living in the service was not seen as a chore but something which was part of their life. They gave us an example of a person dropping in to have a social drink with their relative on the way home from work.

The service had a complaints policy and procedure for dealing with any complaints or concerns. People told us they would feel confident talking to a member of staff or the management team if they had a concern or wished to raise a complaint. Staff confirmed they knew what action to take should someone in their care want to make a complaint and were confident the management team would deal with the complaint appropriately. To date no formal complaints had been received

Inadequate

Is the service well-led?

Our findings

The management team did not understand the principles of good quality assurance. Quality assurance processes were not used to drive improvement.

We asked one of the mangers if there was a quality assurance procedure to ensure care plans were of good quality and contained all the required information. They told us that they had reviewed one care plan in the last six months but that there were no systems in place to regularly review care plans. Lack of oversight of care plans by the management team could mean that care plans were of poor quality and did not provide staff with sufficient information to meet people's needs.

When asked if there were any other quality assurance audits such as cleaning audits, infection control audits or a general audit of the condition of the building we were told that these had not been formally established. Lack of monitoring of this part of the service could result in infection control problems and deterioration of the environment not being identified before impacting on the lives of people or staff.

Accidents and incidents were recorded but there was no process in place to monitor these for trends or re-occurrences. A quality assurance survey had been carried out and the results analysed but no action had been taken to address the results. This meant that repeated accident with a similar cause or trends in the cause of accidents were not identified. Also if the accident records had been monitored the management team may have noted that the use of restraint had been recorded incorrectly.

We were told by the mangers that the provider visited the service regularly. However, they did not carry out any formal audits of the service and a record of their visits was not kept. As a registered person the provider has a duty to assure themselves of the quality of the service being provided.

The service held regular meetings between management and staff. Staff had told us that they were being asked to work excessive hours, did not know how to book annual leave and did not have a contract. We asked the registered managers about this. They told us that staff contracts were in the process of being re-issued. They said they had no knowledge of staff concerns about working excessive hours. However, minutes of a staff meeting showed that the issue of the number of hours worked by staff had been brought up at a staff meeting. This demonstrated a lack of communication and awareness by the management team regarding the day-to-day issues that caused staff concern.

We were not assured as to the accuracy of some records. For example two members of staff told us that they had not received training in a particular area. The service record showed that staff had been trained. When we queried this with the management team they agreed that one person who was shown as completing the training had not. Inaccuracies in records of this type could mean that people received care and support from inadequately trained staff.

The above represents a breach of Regulation 17(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's records were kept securely in cabinets in rooms with restricted access. Access to computer records was secured with password access. The service had a CCTV system for communal areas. Recordings were kept securely and a policy and procedure regarding access to recordings was in place.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 17 HSCA (RA) Regulations 2014 Good governance **The service was not assessing and monitoring the quality and safety of the service provided.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Appropriate consent was not obtained prior to providing care and support.**