

Manderville Care Ltd

The Old Vicarage

Inspection report

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Date of inspection visit:
16 December 2016
05 January 2017

Date of publication:
24 March 2017

Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Good ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Good ●

Is the service responsive?

Good ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

The inspection took place on 16 December 2016 and was unannounced. A second day of inspection took place on 5 January 2017. We last inspected the service on 19 November 2014 and found the service was in breach of regulations as windows weren't fitted with appropriate restrictors. We completed a focussed inspection in June 2015 and found the service had made improvements.

The Old Vicarage is a home providing personal and nursing care to a maximum of 28 people, including those living with dementia. At the time of the inspection there were 12 people living in the home.

During the inspection we found the service had breached a regulation. The training matrix demonstrated that not all staff had received training in areas such as moving and handling, safeguarding, Mental Capacity Act 2005, Deprivation of Liberty Safeguards and infection control. There was very little evidence of training for the permanent nurses and no evidence of training for agency nurses currently providing cover in the home.

The manager was not registered at the time of the inspection. 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.

Staff had not received annual appraisals to discuss their performance and development. Staff had attended some up to date training but other training required updating. Staff received regular supervisions to discuss any issues and their performance in their roles as well as identify specific training.

Staff had an understanding about safeguarding people and were confident in their roles. People's medicines were administered and managed in a safe way.

Risks to people's health and wellbeing were identified, assessed and managed. People had care plans in place to manage risks and reduce the likelihood.

People and relatives told us there were enough staff to meet people's needs. The registered provider was in the process of designing a dependency tool to enable a more effective analysis of staffing requirements to ensure people's needs were met. There was no timescale for implementation at the time of the inspection.

New staff members were recruited in a safe way. All necessary checks were carried out including references and checks with the Disclosure and Barring Service.

There were appropriate Mental Capacity Act (2005) assessments, best interest decisions and Deprivation of Liberty Safeguard authorisations in place for people who lacked capacity to make specific decisions in relation to their care needs.

People were supported to meet their nutritional needs where required. We observed a mealtime experience and saw staff provided verbal prompts and physical support, where required, to assist people with their meals.

Records showed that people accessed a wide range of health care professionals including GPs, district nurses, chiropodists and audiologists.

Staff treated people with dignity and respect. They interacted with people in a warm and friendly manner.

People had care plans in place that were personalised to their individual needs and included personal preferences and wishes.

People and relatives knew how to raise any concerns they had about the service and felt confident to do so. The manager had a complaints file in place but no complaints had been received at the point of the inspection.

The service provider had quality audit processes and procedures in place to monitor service provision.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

Staff and the manager were confident in their roles to safeguard people from abuse.

All risks to people's health and wellbeing had been assessed and managed.

There were enough staff to meet people's needs and staff were recruited in a safe way.

Is the service effective?

Requires Improvement ●

The service was not always effective.

Staff did not have up to date appraisals to monitor their performance and development effectively.

Staff had received some up to date training and regular supervisions.

People had access to a wide variety of health professionals.

Is the service caring?

Good ●

The service was caring.

People and their relatives were happy with the support provided.

Staff interacted positively with people. They treated people with dignity and respect while providing support.

People could access appropriate advocacy services.

Is the service responsive?

Good ●

The service was responsive.

Care plans were personalised and included people's individual preferences.

There was a range of activities available in the home for people.

People and relatives knew how to raise concerns and felt confident to do so.

Is the service well-led?

The service was not always well-led.

The manager was not registered at the time of the inspection.

The registered provider had not submitted a notification to the Care Quality Commission regarding the absence of the former registered manager.

Appropriate audit processes were in place to monitor the quality of service provision.

Requires Improvement ●

The Old Vicarage

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 16 December 2016 and was announced. A second day of inspection took place on 5 January 2017.

The inspection team consisted of one adult social care inspector and one 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 who supported this inspection was experienced in providing care for older people and people living with dementia.

Before the inspection we asked the provider to complete 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. This was completed and returned within the required deadline.

We reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We contacted the local authority commissioners of the service, the local authority safeguarding team and the clinical commissioning group.

We spoke with three people who used the service and two relatives. We also spoke with the manager, one senior care worker and three care workers. We looked at the care records for four people who used the service, medicines records for five people and recruitment records for three staff. We also looked at records about the management of the service, including training records and quality audits.

Is the service safe?

Our findings

People we spoke with told us they felt safe living at The Old Vicarage. One person said, "I feel safe and if I want anything done the staff help." Another person commented that they "feel safe" receiving support. A relative told us, "When [family member] was at [previous care home] for a year, I had to come in every day to check on his care, but here I can come in every two days as the carers are so good." Another relative said, "It's the care and safety that counts and that's what we have got with these wonderful carers."

Staff we spoke with told us, "People are safe here." Staff were aware of the policies and procedures to keep people safe, for example safeguarding and whistleblowing. Staff told us they would speak to the manager if they had any concerns about the safety and welfare of the people who lived in The Old Vicarage. The home kept records of all safeguarding referrals made to the local authority and the subsequent action taken. Records showed safeguarding concerns were investigated, actioned and outcomes were documented.

People had risk assessments in place where required. Risk assessments were stored within care files and were regularly reviewed. All identified risks had appropriate care plans in place which detailed how people should be supported to manage those risks. For example, those at risk of falls had a falls risk assessment in place as well as a moving and handling risk assessment and had appropriate equipment in place to reduce the risk of falls including wheelchairs and walking aids.

In addition to people's individual risk assessments there were a range of general risk assessments in place for the premises and the environment. For example, manual handling, slips, trips and falls, legionella and infection control. All risk assessments we viewed had been reviewed on a regular basis to keep them up to date and relevant to the service.

Medicines were administered safely and stored appropriately. All medicine administration records (MARs) were completed in full with reasons for non-administration recorded. For example, due to a person being hospitalised. Unused medicines were returned to the pharmacy in a timely manner. Regular medicines audits were carried out by the manager to identify any medicines errors. Anyone receiving 'when needed' medicines had protocols in place on care files to direct staff when to administer or offer medicines to individuals. We viewed completed abbey pain scale charts in some people's care files, for staff to assess whether people were experiencing pain who were unable to communicate this to them. A relative told us, "[Family member] gets his tablets religiously every 4 hours."

Staff and relatives felt there were enough staff to support people and meet their needs. One person said, "There's always someone to help." A relative told us, "[Family member] had an accident this morning but the carers came straight in as he didn't have time to press the buzzer and everything was sorted."

The manager told us they felt staffing levels were organised based on the needs of people using the service. They told us there were already plans in place to increase staffing levels as and when more people were admitted to the service based on their needs. The registered provider had a plan in place to introduce a more robust system to analyse staffing levels and ensure sufficient levels of staff were in place to meet

people's needs. The manager explained a clinical lead was in the process of developing this and it would be based on the skill mix of staff, dependency of people using the service and the layout of the building. At the time of the inspection there was no timescale identified for when this tool would be implemented. During our inspection we observed people were given support by staff in a timely manner and at a pace comfortable to each person. People were not left unassisted for long periods of time and nurse call bells were answered promptly.

The registered provider continued to practice safe recruitment methods. Records of newly recruited staff members evidenced that all appropriate checks were carried out. They included obtaining suitable references and checks with the disclosure and barring service (DBS). DBS checks are used as a means to assess someone's suitability to work with vulnerable people and to check that they were not barred from doing so.

The registered provider maintained an accidents and incidents log to record any occurrences. Records included details of people involved, what happened and what action was taken. For example, a referral to the falls team and ordering equipment to support the person when mobilising around the home.

Personal emergency evacuation plans (PEEPs) were in place for every person who used the service. These included details about the support each person required, how many staff were needed and any equipment to be used. We saw plans were updated in line with the changing needs of people. This meant staff had guidance about how to support people during an evacuation.

During our inspection we saw appropriate maintenance records for all lifting equipment. Lifting equipment had been inspected in line with LOLER six monthly. The manager ensured maintenance checks had been completed and identified when new checks were due to ensure maintenance of equipment was consistent.

The home had recently undergone some refurbishment works with decoration and new carpets in the entrance area. New carpets had also been laid in the communal lounge on the first floor. The manager told us there were ongoing plans in place to refurbish other areas of the home to freshen up the décor.

Is the service effective?

Our findings

Staff appraisals were out of date and had not been completed since 2015. Records showed staff had received appraisals at different times through 2015. The manager showed us their plan to complete appraisals with staff in March 2017. They told us they didn't feel able to complete appraisals before this time as they need to acquire more of an insight into individual staff member's performance. This meant the manager was unable to determine each staff member's performance and development.

The staff training matrix produced by the manager showed that not all staff had completed training in areas such as health and safety, first aid, safeguarding, infection control, MCA and DoLS. There was little or no evidence of training for both permanent and agency nurses. We spoke with the manager about this who informed that they had created and updated the training matrix from certificates in staff files. They went on to explain that some staff had confirmed they had received training in specific areas but the certificates were not evident on staff files.

The manager told us they were seeking appropriate training for staff where no records were present in files as well as refresher training for all staff. They were also organising some e-learning for staff. Due to lack of records we were unable to confirm that all staff were suitably trained to carry out their roles.

This was a breach of Regulation 18 (Staffing) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives we spoke with said they felt staff had the skills to do their job. A relative we spoke with said, "Staff are brilliant. One good thing about the service and care here is if [family member] needs anything they are there."

Records showed staff received regular supervisions. From staff files we noted discussions included any issues or concerns, records, policies and procedures and training. Staff were encouraged by the manager during supervisions to share any ideas to improve service provision. Any agreed actions were recorded and were followed up during the next supervisions. For example, to complete specific training.

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 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 checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

People's care records contained best interest decisions which corresponded to the information contained in the DoLS authorisations. Restrictive processes and decision making were reflected in people's care plans. For example, the use of a lap belt on a wheelchair to reduce the risk of a person falling from their wheelchair. Staff understood the importance of gaining people's consent prior to providing support. During the inspection we observed staff gaining people's permission prior to support them with specific tasks such as mobilising around the home. Staff also understood that some people living in the home were subject to DoLS authorisations and were unable to leave the home unsupervised for their own safety.

The home had a system in place to monitor and reduce the risks associated with malnutrition and dehydration for people. People with identified risks had a malnutrition universal screening tools (MUST) in place to monitor weight loss and BMI. A MUST tool is a five-step screening tool used to identify if people are malnourished, at risk of malnutrition or are overweight. For people who had specific dietary requirements a care plan was in place which included: food allergies, special dietary requirements, preferred drinks and the person's dietary likes and dislikes. They also had food and/or fluid intake monitoring sheets completed to allow staff to monitor people's health and wellbeing.

We observed a meal time experience in the dining room. The atmosphere was relaxed and people were served their food in a polite, and respectful manner. Staff encouraged people to eat independently where possible. People who required support to eat their meals were patiently supported at a pace comfortable to them. We observed people smiling and engaging with staff whilst eating their lunch.

People had a choice of two dishes every mealtime and the service offered alternatives for those with specific dietary requirements or who didn't want either of the planned options. For example, a sandwiches and jacket potatoes instead of a heavier meal.

People had access to health professionals when required. Records showed people had received support from professionals including GPs, district nurses, chiropodists, occupational therapists, speech and language therapists, dermatologist and audiologists.

Is the service caring?

Our findings

People and relatives gave us positive feedback about the care provided at the service. One person said, "I'm treated great. Staff are lovely and everything is clean." Another person told us, "Staff are great. They kid me up and I kid on with them and (they) make me laugh."

The atmosphere within The Old Vicarage was relaxed, warm and welcoming. People and relatives told us the atmosphere in the home was "quite good".

During our inspection we observed staff supporting people with daily tasks, such as eating, drinking and doing day to day activities. We also observed people receiving physical support when moving around the home with and without equipment. People were supported to make individual choices and decisions where possible. For example, one person who required support with mobilising, wished to stay in the dining room following their lunch, but then changed their mind and wanted to go into the lounge. Staff supported them to do so.

Throughout the inspection we observed staff treated people with dignity and respect. Staff spoke to people in a respectful and polite manner, and referred to them by their preferred name and with familiarity. We observed staff knocking on people's doors prior to entering. We observed staff offering support to people and gaining their consent before providing it. For example, when supporting a person to mobilise from the dining room to the lounge following their lunch. One person said, "They (staff) treat me with dignity and my son and daughter come in when they want and sometimes take me out." A relative told us, "[Family member] is definitely treated with dignity. They (staff) treat them as though they were their own [family]. They chat along with him (in his chosen topic of conversation)."

Staff spoke about people with genuine affection. They knew what individual people liked to do and had interests in and could explain people's daily routines. Staff supported people gently and patiently, providing prompts and encouragement when required and at a pace comfortable to each individual. We observed staff engaging people in conversation as well as watching television with them.

At the time of the inspection no one required the support of an advocate. The manager told us, "If anyone needed one we would support them to get one. There are local independent services we could contact." They also went on to say they would contact the local authority for information on suitable advocacy services also.

At the time of the inspection no one was in receipt of end of life care. However, care plans we viewed contained details of people's end of life wishes and some people had DNACPR agreements in place. One person's wishes included that they wished to remain in the home and not attend hospital unless they showed ailments that could be treated.

Is the service responsive?

Our findings

People had their needs assessed prior to receiving care and support. The assessment was used to gather personal information about people to help staff better understand their needs. This included a life history and their existing support network. The assessment also included communication needs, daily living skills, medicines and the person's social interests.

People had a range of care plans in place to meet their needs including personal care, eating and drinking, medicines, skin integrity, continence and mobility. Care plans were personalised and included people's choices, preferences, likes and dislikes. For example, one person's eating and drinking care plan stated the person 'likes to eat all of [their] meals in the dining room with other residents and staff. There was also some detail around people's typical daily routines. For example, one person's care plan stated they liked to go to their room to watch television or listen to the radio after their evening meal. Care plans contained relevant detail and clear directions to inform staff how to meet the specific needs of each person.

Care plans were reviewed on a regular basis, as well as when people's needs changed. All care plans we reviewed were up to date and reflected the needs of each individual person. Relatives told us they were involved in reviewing care plans of their family members.

There was a weekly programme of activities for people living in the home which included arts and crafts, bingo, sit and be fit, board games, films, baking and sing along. There was also a pool table in the conservatory for people to use. A staff member told us if people didn't wish to participate in the scheduled activities they asked them what they would like to do and tried to accommodate their wishes and interests. This meant there were things for everyone to do in line with their own interests and preferences.

The registered provider had made specific adaptations within the home to improve the quality of life for people living with dementia. For example, bedroom doors, handrails, toilet doors and toilet seats were brightly painted to give clear direction to people living with dementia.

Dementia friendly signage was also available around the home containing pictures as well as words to help people locate areas in the home such as the lounge, dining room, kitchen, conservatory and bathrooms. During our inspection we observed people living with dementia orienteering around the home freely and getting to places they wanted to go. For example, one person was in the dining room and had finished their lunch when staff asked them where they wanted to go. The person told them they wanted to go to the lounge then subsequently left the dining room and made their way to the lounge area.

The registered provider had a complaints procedure in place. The manager had implemented a complaints file and log. There had been no complaints received in the last 12 months. People and relatives told us they knew how to raise concerns and issues. One person told us, "On the occasions when I've objected to anything it has been sorted." Another person said, "I have no complaints". A relative said, "If there is a problem I think I could certainly go to the manager." Another relative commented, "No complaints. None whatsoever. I couldn't ask for any better."

Is the service well-led?

Our findings

The service had a registered manager at the time of the inspection. However, they hadn't been active in the service since July 2016. During the inspection we noted the registered provider had failed to notify the Care Quality Commission about the absence and departure of the registered manager. Other statutory notifications that are required to be submitted to the Care Quality Commission had been sent in a timely manner. There had been a few changes with interim managers following the departure of the registered manager. The manager who was currently overseeing the day to day delivery of service provision told us they planned to commence the registration process.

People and relatives spoke highly of care workers and the new manager. They told us they felt the manager was approachable and the care was exceptional. One person said, "[Manager] is a nice person but most importantly he listens." A relative said, "[Manager] is very nice and always asks 'is everything all right'."

Staff told us they felt "things were much better now". They also said they felt they were "well-led" by the new manager.

Throughout the inspection visits there was a management presence in the home with the manager readily available for staff, people who use the service, relatives and other professionals to speak to.

Staff had not received annual appraisals to discuss their performance and potential development needs. This meant the manager was unable to determine what level of support each member of staff required. The new manager showed us their plan to complete all staff appraisals in March 2017 once they had more insight into staff performance.

During out of hours, the manager told us that there were on-call arrangements in place. The manager told us, "They can contact me twenty-four seven." They went on to tell us that staff could also contact the governance director if they were unavailable. Contact details for out of hours arrangements were available in the staff room. This meant staff had access to management for advice and guidance at all times.

The home had a system in place for the daily handover of information. A senior care worker told us, "We handover information twice a day; day and night shift, about daily reports." This included verbal handovers which incorporated daily reports for each person. The senior staff on both day and night shifts shared necessary information with each other and both signed the handover form to confirm this. Information included issues or concerns with individual people who required additional monitoring due to being unwell or displaying behaviours or mannerisms out of the ordinary.

There was also a diary which was used to record and communicate specific information between staff. For example, appointments booked with various health professionals as well as other things such as equipment to be ordered, appointments to be made and pharmacies to be contacted. Actions were recorded when completed or updated when unable to be completed at specific times. This meant staff had up to date information to support people in maintaining their health and wellbeing.

The registered provider held regular staff meetings to discuss the quality and development of service provision. Minutes included discussions around management changes, refurbishment of the home and facilities, people, care plans and staff rotas. Records also showed staff were consulted on systems in the home. For example, the staff rota system.

The manager completed a number of audits in the home which varied in frequency. Audits included fire safety checks and medicine audits. Other audits regularly carried out related to areas such as infection control, the dining experience, care plans and staff files. These were effective in identifying issues and the required actions to make improvements.

The manager completed monthly reports which were submitted to the registered provider. From reports we viewed, we noted information included accidents and incidents, safeguarding concerns, bed rail audits, any complaints received, people with pressure damage and monthly weights. Records including details of people, actions the manager had taken, any health and social care professionals or regulators involved and outcomes. The manager informed us that the registered provider viewed reports and fed back to them if there was any other action they needed to undertake or to discuss further if required.

The registered provider consulted people and relatives about the service and environment. One relative told us they had made comment on the service but previous management hadn't taken action. They told us the new manager listened and took necessary action in relation to their comments.

Satisfaction surveys were sent to people and relatives in May 2016. There were 10 responses which were mostly positive about the service. Negative feedback focussed on the décor of the home and activities. Records and observations confirmed that remedial actions had taken place to resolve shortfalls in the service. For example, the remove of net curtains in the conservatory and placing bird tables and feeders in the garden for people to watch birds out of the window.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Treatment of disease, disorder or injury	Not all staff had received relevant training to carry out their roles.